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THE UNIVERSITY OF ALBERTA

SUSPENSION AND TERMINATION OF EMPLOYMENT AMONG NURSES IN CANADA

by

MARILYN DARLENE STEVEN

A THESIS
SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH
IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE
OF DOCTOR OF PHILOSOPHY

DEPARTMENT OF EDUCATIONAL ADMINISTRATION

EDMONTON, ALBERTA
SPRING 1988

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Date: April 11, 1988

DEDICATION

This dissertation is dedicated to:

- All nurses in Canada and in particular those individuals named below for their commitment and dedication to nursing practise, education, administration and research.

  Professor Margaret Page
  Professor Margaret Boone
  Mrs. Rose Sinclair
  Dr. Josephine Flaherty
  Dr. Judith Hibberd
  Dr. Shirley Stinson

- My grandparents, Mary Steven and the late James M. Steven for their love, patience, and understanding.

And

- In memory of Miss Glenna Rowsell.

ABSTRACT

Nurses are being held increasingly responsible and accountable for their actions by judges, arbitrators, professional associations and the public. The major purpose of this study was to examine unacceptable nursing practises in public hospitals using examples from case law, arbitration and professional discipline cases.

The methodology utilized in this study was content analysis incorporating grounded theory. The sources of data were: case documents (published and unpublished), legal documents and interviews. In order to analyze the cases in a logical sequence, a schematic presentation for classifying unacceptable nursing behaviours identified in legal, arbitral and professional discipline cases was developed by the investigator. In total, 107 cases were examined and incorporated into the study: 24 legal cases, 40 arbitration cases, and 43 professional discipline cases.

The findings of the study were as follows:

1. Nurses are facing lawsuits for: (a) failure to provide an established standard of care, (b) failure to administer medications following established hospital policies and procedures, (c) failure to carry out a procedure according to established hospital policies and procedures, (d) failure to document the patient's record in an appropriate manner, and (e) failure to ensure

that the unit has adequate staff coverage prior to leaving for a break.

2. There appear to be discrepancies in the awards handed down by arbitrators, especially in regards to professional issues, i.e., medication errors.

3. The terms negligence, incompetence and misconduct have been frequently interchanged and often misused by arbitrators.

4. The disciplinary process of the professional association varied in the provinces and territories in regards to the complaint procedure, the investigation procedure, and the appeal procedure.

5. The definitions for incompetence (unskilled practise), improper conduct or professional misconduct were used differently in various provinces and the territories.

6. There appear to be discrepancies in the types of professional disciplinary action imposed in various provinces and the territories.

It was concluded that legal, economic, political, socio-cultural and professional factors have had a major impact on the practise of nursing. The investigator contributed to enhancing Dunlop's theoretical model of the industrial relations system by including the concepts of professional environment, professional discipline and professional issues. Based upon the findings of this study, implications were presented for employers, arbitrators, professional associations, nursing unions, nurse practitioners, nurse administrators, and nurse educators. It is envisioned that privatization of health services, cost constraints in all types of health care settings, and public awareness will have an effect on increasing the number and types of legal, arbitral, and professional discipline cases in the future.

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TABLE OF CONTENTS

Chapter Page

1 INTRODUCTION 1

Statement of the Problem 1

Justification for the Study 2

Theoretical Significance 2

Practical Significance 3

Review of Related Theory 5

Conceptual Framework 7

Research Design 11

Delimitations 13

Limitations 13

Definition of Terms 14

Organization of the Remainder of This Dissertation 17

2 A REVIEW OF THE LITERATURE ON PROFESSIONALISM AND COMPETENCY IN NURSING PRACTICE 18

Introduction 18

An Overview of the Components of a Profession 22

Definition of a Profession 22

The Components of a Profession As It Applies to Nursing 25

A systematic body of knowledge 28

Professional authority 30

Community sanction 34

Chapter Page

A code of ethics 42

The professional culture 44

Competency in Nursing Practice 50

Introduction: The Discrepancy between Education and Practice 50

An Overview of the Literature on Competency in Nursing Practice 51

Competency Defined 51

Competency-Based Education 52

Competency-Based Practice 53

Competency of student nurses 54

Competency of nurse practitioners . . 58

Competency of nursing administrators . 61

Competency of clinical nurse specialists 61

Summary 63

3 METHODOLOGY 65

Introduction 65

Sources of Data 68

Case Documents 68

Stage 1: Collection of arbitration cases 68

Stage 2: Collection of legal cases . 69

Stage 3: Collection of information related to professional discipline . . 70

Legal Documents 71

Interviews 72

Data Analysis 72

Chapter Page

Stage 1: Developing the Categories . . 73

Stage 2: Saturating the Categories . . 74

Stage 3: Abstracting Definitions . . . 74

Stage 4: Using Definitions 75

Stage 5: Exploiting Categories Fully . 76

Stage 6: Noting, Developing and Following-up Links between Categories 77

Stage 7: Considering the Conditions under Which the Links Hold 77

Stage 8: Making Connections, Where Relevant to Existing Theory 78

Stage 9: Using Extreme Comparisons to the Maximum to Test Emerging Relationships 78

Methodological Rigor 81

Summary 84

4 LEGAL CASES: LIABILITY IN NURSING PRACTICE 85

Introduction 85

The Canadian Legal System 87

Functions and Definition of Law 87

Legal Systems 88

Sources of Law 89

Statutes 89

Cases 90

Types of Legal Action 91

Negligence 94

Definition 94

Chapter Page

Direct and Vicarious Liability in Negligence 95

Direct liability 95

Vicarious liability 96

An Overview of the Literature on Nursing and the Law: A Canadian Perspective . . . 99

Negligence Versus Malpractice 99

General Considerations in Negligence . . 100

Standard of care 101

Documentation 102

Failure to provide adequate coverage . 104

A Review of Selected Legal Cases 107

Civil Lawsuits and Nurse Negligence . . 107

Patient related negligence 109

Medication related negligence 112

Procedure related negligence 116

Civil lawsuits and dismissal cases . . 119

Criminal lawsuit and a public inquiry 123

Summary 130

5 ARBITRATION CASES: SUSPENSION AND TERMINATION FROM EMPLOYMENT 132

Introduction 132

Dismissal for "Just Cause": An Overview . 134

Definition of Just Cause 135

Historical Underpinnings: Common Law . 136

Legislative Enactments 137

The Grievance Arbitration Process 138

Chapter Page

Introduction 138

The Grievance Process 139

The Arbitration Process 141

Appointment of the arbitration tribunal 141

The hearing 142

The nature of the award 143

General Considerations in Arbitration Cases 144

Prior Record of the Employee 144

Culminating Incident 146

Organizational Rules and Regulations . . 147

Progressive Discipline: Warnings, Performance Appraisals, Anecdotal Records 150

Probationary Employees 156

Resignation or Dismissal 159

Arbitration Cases: A Selected Case Review 163

Incompetence 163

Introduction 163

General incompetence 165

Medication errors 170

Insubordination 184

Neglect of Duty 188

Professional Misconduct 192

Theft 192

Breach of confidentiality 193

Chapter Page

Force feeding 194

Criminal conviction 195

Patient abuse 197

Falsification of employment records . 202

Absenteeism 204

General 204

Illness 207

Use of Alcohol or Other Drugs. 213

Dismissal on Religious Grounds 215

Miscellaneous 216

Summary 218

6 PROFESSIONAL DISCIPLINE 224

Legislation Governing Professional Discipline 224

Alberta 224

British Columbia 227

Manitoba 231

New Brunswick 234

Newfoundland 238

Northwest Territories 239

Nova Scotia 242

Ontario 245

Prince Edward Island 248

Quebec 249

Saskatchewan 252

Yukon 254

Chapter Page

Summary and Discussion of Legislation Governing Professional Discipline . . . 254

Discipline Cases in Various Provinces . . 268

Alberta 268

British Columbia 271

Manitoba 277

New Brunswick 277

Newfoundland 277

Northwest Territories 281

Nova Scotia 282

Ontario 282

Prince Edward Island 294

Quebec 294

Saskatchewan 301

Summary 302

7 AN ANALYSIS OF THE FINDINGS 306

Introduction 306

Legal Cases 307

Unacceptable Nursing Behaviours Identified in Patient Related Cases . . 309

Unacceptable Nursing Behaviours Identified in Medication Related Cases 309

Unacceptable Nursing Behaviours Identified in Procedure Related Cases . 310

Arbitration Cases 311

Incompetence 314

Medication errors 315

Chapter Page
Insubordination 316
Neglect of Duty 317
Professional Misconduct 317
Absences 317
General 317
Illness 317
Alcohol and Drug Related Cases 318
Dismissal on Religious Grounds 318
Miscellaneous Cases 318
Professional Discipline Cases 319
Incompetence 322
Professional Misconduct 323
Professional Misconduct (Medication Related) 325
Operational Definitions 326
Negligence 326
Incompetence 327
Unskilled Practise, Improper Conduct or Professional Misconduct 330
Conclusion 337
8 SUMMARY, CONCLUSIONS AND IMPLICATIONS OF THE STUDY 338
Problem and Procedures of the Study . . . 338
Problem and Sub-Problems 338
Limitations of the Study 339
Literature Review 340
Methodology 341

Chapter Page

Findings of the Study 342
  Legal Cases 342
  Arbitration Cases 343
  Professional Discipline Cases 345
  Operational Definitions 346
    Negligence 347
    Incompetence or unskilled practise . . 348
    Improper conduct or professional misconduct 350
Summary of the Findings of the Study . . . 353
Conclusions of the Study 354
Implications of the Study 355
  Implications for Employers 356
  Implications for Arbitrators 358
  Implications for Professional Associations and Nursing Unions 359
  Implications for Practising Nurses . . . 361
  Implications for Nursing Administrators 364
  Implications for Nurse Educators 371
  Implications for Further Theorizing in This Area 373
  Implications for Further Research . . . 374
Concluding Comment 377

BIBLIOGRAPHY 378

APPENDIX A. DEFINITIONS 433

APPENDIX B. SAMPLE OF LETTER FORWARDED TO PROVINCIAL NURSING ASSOCIATIONS 440

Page

APPENDIX C. A COMPARISON OF THE PRESENT REGISTERED NURSES' ACT OF BRITISH COLUMBIA WITH PROPOSED AMENDMENTS 445

VITA 462

LIST OF TABLES

Table		Page
6.1	Summary of Legislation Governing Professional Practice	255
6.2	An Outline of Definitions of Professional Misconduct and Incompetence	259
6.3	A Summary of Professional Discipline Cases in Alberta, 1973-1986	269
6.4	Discipline Findings and Actions: Registered Nurses' Association of British Columbia 1975-1989	272
6.5	A Summary of Professional Discipline Cases in Manitoba, 1973-1986	278
6.6	A Summary of Professional Discipline Hearings in Newfoundland, 1973-1986	280
6.7	A Summary of Professional Discipline Cases in Ontario, 1975-1986	284
6.8	Professional Discipline Charges in Quebec, 1978-1985	296
7.1	Types of Legal Cases Involving Canadian Nurses During the Period 1904 through 1987	308
7.2	A Summary of Arbitration Cases Involving Suspension of Employment Among Nurses in in Canada for the Period 1973 through 1986	312
7.3	A Summary of Arbitration Cases Involving Dismissal from Employment Among Nurses in Canada for the Period 1973 through 1986	313
7.4	A Summary of Professional Discipline Cases Heard by the Discipline Committee in Each Provincial Jurisdiction and the Territories During the Period 1973 through 1986	320
8.1	A Summary of Professional Issues and Suggested Processes for Discipline of Employees for Nurse Administrators	365

LIST OF FIGURES

Figure Page

1.1 A Modified Version of the Industrial Relations System 8

2.1 A Comparison of the Roles and Responsibilities of Professional Associations and Nursing Unions 46

3.1 A Schematic Presentation Used in Classifying Unacceptable Nurse Behaviours Identified in Legal, Arbitral and Professional Discipline Cases 79

4.1 A Schematic Presentation for Classifying Unacceptable Nurse Behaviours Identified in Legal Cases 108

5.1 A Schematic Presentation for Classifying Unacceptable Nurse Behaviours Identified in Arbitral Cases 162

6.1 Organizations Representing Nurses in Ontario 246

6.2 A Schematic Presentation for Classifying Unacceptable Nurse Behaviours Identified in Professional Discipline Cases 266

Chapter 1

INTRODUCTION

Statement of the Problem

The problem of the study was to define unacceptable professional nursing practise in public hospitals using examples from case law, arbitration cases, and professional discipline cases as these relate to disciplinary action against nurses in Canada.

The sub-problems of this study were:

1. To determine the types of nurse behaviours which resulted in negligence lawsuits and the legal consequences of these behaviours.

2. To determine from arbitration cases, the types of nurse behaviours which resulted in suspension or termination from employment and the arbitral consequences of these behaviours.

3. To determine the types of nurse behaviours which resulted in disciplinary actions by the professional association.

4. To provide operational definitions of negligence, incompetence or unskilled practise, and professional misconduct based upon the findings of the study.

Justification for the Study

The study has theoretical and practical significance for all professionals as it relates specifically to clearer definitions of professional obligations, legal responsibilities, employment responsibilities. and the collective bargaining process. Swan (1979) cites two parallel developments occurring in various professional sectors:

> First, there is an increasing tendency to define, in collective agreements, the nature of the professional relationship and the rights and privileges which attach to it—and to make this definition binding on both the employer and individual employees. Second, there has been a parallel development, in the arbitration jurisprudence, of standards of professional behaviour and professional privilege to be applied in cases where an employer seeks to discipline a professional. (p. 99)

The impact of these developments has serious implications for educators, administrators, employers, professional associations, unions representing professional employees, and ultimately the practitioner.

Theoretical Significance

This study advances theoretical concepts related to labour relations, collective bargaining and professionalism. Ponak (1981) contends that unionized professionals will "seek to expand the scope of negotiations to include professional concerns," referred to as the expansion of bargaining thesis (p. 396). The expansion of bargaining thesis is "rooted in concepts of professionalism and the nature of work in large bureaucratic organizations" (p. 397). However, often these ideologies conflict since "professionals hold a distinctive set of values that is a central focus in their work, and . . . the nature of large organizations inhibits their ability to achieve these values" (p. 397). Ponak further contends that:

> . . . because collective bargaining is a process that is capable of effecting changes in a work environment . . . concerns that relate to professional aspects of work will become key bargaining goals of unionized professionals. (p. 398)

In nursing unions across Canada professional concerns have already been addressed through the negotiation of collective agreements which contain clauses relating to the establishment of Nursing Advisory Committees, a committee comprised of union and management representatives whose main function is to address professional concerns in the work environment, i.e., staffing, workload, and policies and procedures related to nursing practise. Yet, few scholars have attempted to delineate professional issues in labour relations and collective bargaining theories. The proposed study is designed to add to the body of knowledge on collective bargaining and labour relations theory.

Practical Significance

In the last decade, several precedent setting cases in arbitral jurisprudence have occurred involving such factors as workload and staffing ratios (e.g., Mt. Sinai Hospital and Ontario Nurses' Association, 1978). The Board of Arbitration in the Mount Sinai case ruled that there is a "need for a mechanism to protect the individual nurse from situations which might compromise her professional integrity and render her professionally vulnerable" (Swan, 1979, p. 102).

In December 1986, in another case, an arbitrator upheld the decision of the employer to dismiss a nurse because of a medication error. The impact of this decision may have serious implications for the profession. The decision was made by an arbitrator even though an expert witness testified that there is a ten percent medication error rate in hospitals and even further, the professional association in that province did not find justification for investigating the action further and did not take any disciplinary action against the nurse (Midale Hospital and Saskatchewan Union of Nurses, 1986). In addition, there were environmental factors not even considered in the case, which had increased the likelihood of the nurse making an error.

Swan (1979) poses two questions relevant to the research being undertaken:

> - What form of disciplinary action is appropriate for professionals?
> - What special responsibilities do professionals owe to their employers by reason of their professional status? (pp. 102-103)

These questions will likely be addressed in the future through the use of specific clauses in collective agreements. An even more perplexing question that is being raised in various professions is what constitutes competence versus incompetence and how are negligence, professional misconduct, and unskilled practise defined. Further to this question is the question concerning who disciplines. The employer? The professional association? The judicial system? The arbitral jurisprudence system? In reality, a professional may find himself in the unique situation of multiple risk: being dismissed from one's position, having to appear at an arbitration hearing as a result of being dismissed, being investigated by the professional association, and facing a lawsuit for negligence. These questions and the hypothetical illustration presented are addressed in this study.

Review of Related Theory

The underlying theory most relevant to this study is in the realm of industrial and labour relations. The term industrial relations refers to the nature of employment relationships in an industrialized setting. Craig (1983) states:

> . . . it is possible to define the field of industrial relations as comprising a complex of private and public activities, operating in a specified environment which is concerned with the allocation of rewards to employees for their services and the conditions under which these services are rendered. The phrase "complex of private and public

> activities" is meant to include all structural arrangements and processes related to the field of study. "Operating in a specified environment" implies that an industrial relations system functions dynamically in relation to the environmental subsystems of a given society. "Rewards to employees for their services" includes those social and psychological rewards, as well as the material rewards, that employees receive for the performance of their work. (pp. 1-2)

Anderson and Gunderson (1982) in their book titled, "Union Management Relations in Canada," offer comments about the interpretation of this definition:

> Industrial relations . . . does not refer solely to the role of unions and collective bargaining in employment but also encompasses the role and impact of employment related legislation enacted by the federal and provincial governments (for example, minimum wages and standards, worker's compensation, occupational health and safety, and unemployment insurance); and the role of the labour market in establishing the terms and conditions of employment for individuals across occupations, industries and regions. (p. 2)

Thompson (1982), Ponak (1981) and Swan (1978) assert that inherent in this definition is the need to add professional concerns since: (1) professionals are becoming more unionized; and (2) far from undermining professionalism, collective bargaining can be seen as an "instrument of a professional's institution, its nurture, and its protection" (Swan, 1978, p. 107).

Dunlop (1958) conceptualized one of the first and most controversial theoretical frameworks. Dunlop envisioned the industrial relations system of any industrialized setting as being comprised of actors or participants:

1. Acting in conformity with a certain ideology basic to all of the subsystems which bind them together;
2. Interacting within the context of power relationships, market restraints, and technological characteristics of the society; and
3. Developing a body of rules which govern the actors at the work place and in society at large.

Dunlop's theoretical framework has been adapted by Canadian scholars in order to "make the model more amenable to empirical testing" (Anderson & Gunderson, 1982, p. 6). Craig presented a modified version of the industrial relations system which is illustrated in Figure 1.1. This system recognizes the determination of outputs through the conversion processes. This framework was adopted for the proposed research, with the following additions:

1. Professional environment was added to the inputs.
2. Professional discipline was added to the conversion processes.
3. Professional issues was added to the outputs.

Conceptual Framework

Cleland (1978) presents a "Professional Model of Collective Bargaining" based upon research conducted by Baldridge (1971) at the Stanford University Centre for Research and Development in Teaching. Baldridge developed a political model for university governance which reflects

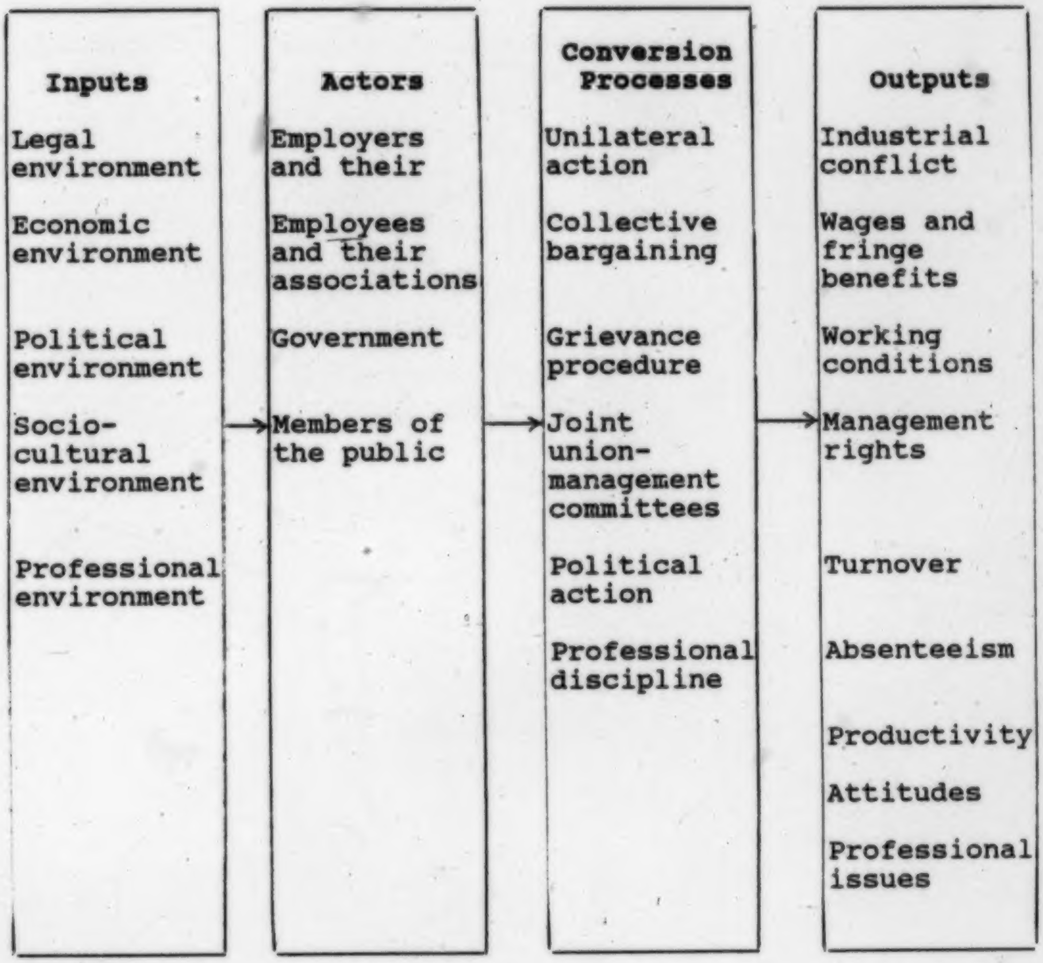
Inputs
Legal environment
Economic environment
Political environment
Socio-cultural environment
Professional environment
Actors
Employers and their
Employees and their associations
Government
Members of the public
Conversion Processes
Unilateral action
Collective bargaining
Grievance procedure
Joint union-management committees
Political action
Professional discipline
Outputs
Industrial conflict
Wages and fringe benefits
Working conditions
Management rights
Turnover
Absenteeism
Productivity
Attitudes
Professional issues

Figure 1.1

A Modified Version of the Industrial Relations System
(Adapted from Anderson & Gunderson, 1982, p. 7.
Used with permission.)

a balance of interest groups seeking to influence university practices. Cleland adapted Baldridge's assumptions in regards to shared governance in a hospital setting:

> 1. Conflict is natural and is to be expected in a dynamic organization.
> 2. The university (hospital) is fragmented into many power blocs and interest groups, and it is natural that they will try to influence policy so that their values and goals will be given primary consideration.
> 3. In the university (hospital), as in other organizations, small groups of political elites govern most of the major decisions. However, this does not mean that one elite group governs everything, but that the decisions are divided, with different elite groups controlling different decisions.
> 4. In spite of this control by elites, there is a democratic tendency in the university (hospital), just as there is in the larger society.
> 5. Formal authority, as prescribed by the bureaucratic system, is severely limited by the political pressure and bargaining power that groups can exert against authorities.
> 6. External interest groups have a great deal of influence on the university (hospital). Internal groups do not have the power to make policies in a vacuum. (p. 41)

The utility of the political model is that it takes into consideration the divergent pressure groups and the pressure they can place on organizations to adopt various goals and practices. In recent years, with the advent of professional nursing unions, practitioners have found that they can exert a great deal of influence on management decisions by utilizing Union-Management meetings and Nursing Advisory Committees to address various professional issues and policy decisions. The

Professional Association for registered nurses, although responsible for setting standards and a Code of Ethics for nurses, has limited power to incorporate these standards into the work setting. The nursing union, however, can influence the degree of incorporation of these standards through various committees and by reporting unsafe working conditions.

A Professional Model of Collective Bargaining as depicted by Cleland (1978):

> 1. Provides for a system of shared governance, through organization of policy-making bodies;
> 2. Acknowledges and supports . . . differences in levels of nursing practice;
> 3. Promotes the development of increased practitioner competence; and
> 4. Supports nursing, institutional, and health system changes developed to improve the effectiveness and quality of care. (p. 40).

This model provides a general framework for the study undertaken in that:

1. Policy-making bodies such as Nursing Advisory Committees and Union-Management Committees are avenues whereby nurses, their representative the union, and management can develop policies and procedures in a collaborative manner in order to ensure that safe patient care is provided.

2. Various levels of educational preparation and specialization are recognized.

3. Nursing competence is promoted through legislation, a code of ethics, peer review and continuing education. Disciplinary action is imposed upon those with

unacceptable behaviours.

4. The model supports research and the setting of standards to improve the quality of care delivered to patients.

Research Design

The methodology conducive to this type of study is that of a social analysis whereby use is made of current and historical data, the technique being the scholarly analysis of the literature (Stinson, 1969).

Specifically, the literature review incorporates:

1. A current literature review of professionalism in nursing with particular reference to accountability and autonomy in nursing practise.

2. A selected literature review encompassing legal liability in nursing, i.e., negligence, incompetence, patient abuse, patient abandonment, and medication errors.

3. A selected literature review of grievance and arbitration procedures.

The literature review is followed by a content analysis of selected precedent cases arising from litigation and arbitration hearings. A review of cases related to litigation and arbitral hearings is fraught with problems. The major problem was in locating the required data. Five primary sources of data for the study were as follows:

1. The Canadian Nurses Association, Labor Relations Division;

2. Unpublished arbitration cases which were forwarded to the researcher from nursing unions across Canada;

3. Published labour arbitration cases in the Labour Arbitration Casebook (Simmons, 1982);

4. Published and unpublished lawsuits available from the University of Alberta, Faculty of Law;

5. Annual reports from professional nursing associations across Canada.

A total of 107 cases were incorporated into the study. Of these, 24 cases relate to negligence suits involving nurses, 40 cases encompass suspension and termination of employment and 43 cases involve professional discipline.

One of the most serious considerations is the validity and reliability of the information presented, specifically as it relates to operational definitions for negligence, incompetence, and professional misconduct. In order to ensure validity and reliability, the researcher: (1) derived definitions from evidence presented in lawsuits and arbitration cases; and (2) compared and contrasted the above derived definitions with definitions developed by the professional association in each province.

Delimitations

The study was delimited as follows:

1. Arbitration cases resulting in suspension and termination of employment among registered nurses in public hospitals;

2. Professional discipline cases resulting in suspension and license revocation; and

3. Legal cases involving negligence and incompetence.

Limitations

1. The majority of cases involving professional discipline are heard in private by members of a Disciplinary Committee or the executive of the professional association. The researcher has limited access to specific information.

2. The number of unpublished arbitration cases that were available from nursing unions across Canada were limited because data retrieval systems were not fully implemented. Approximately 30 unpublished cases have been compiled to date, and it is estimated that a large number are not available.

3. The number of published arbitration cases were limited because data retrieval systems have not yet been established in all provinces and arbitrators are under no obligation to file these cases. Approximately 10

published cases have been compiled to date, and it is estimated that a large number are not available.

Definition of Terms

In order to avoid ambiguity in the words expressed throughout the text of this paper, definitions are presented to assist the reader. (See Appendix A for further definitions.)

Arbitration. A legally established method of settling disputes through the intervention of a third party whose decision is final and binding. Such a third party may be either a single arbitrator or a board consisting of a chairman and one or more representatives. Arbitration is used to settle major grievances and/or settle contract interpretation disputes (Canadian Labour Congress, 1976).

Bargaining Agent. Union designated by a Labour Relations Board as the exclusive representative of all employees in a bargaining unit for the purpose of collective bargaining (Canadian Labour Congress, 1976).

Case Law. This source of law is based on the doctrine of precedent and in common law acts as a guide for judges and adjudicators in deciding future cases (Gall, 1983, p. 31).

Certiorari. A writ of certiorari quashes a decision of a tribunal for reason that the decision was made in a procedurally unfair manner (Gall, 1983, p. 31).

Collective Agreement. A written agreement between one or more unions acting as bargaining agent for employees, and one or more employers which contains provisions for wages, working conditions, fringe benefits, rights of workers and procedures to be followed in settling disputes and grievances (Canadian Labour Congress, 1976).

Dismissal and termination. These terms are often used synonymously and mean discharge or release from employment (Funk & Wagnalls, 1974, p. 383).

Grievance. Complaint against management by one or more employees, or a union, concerning an alleged breach of the collective agreement or an alleged injustice. Procedures for the settling of grievances are usually defined in the collective agreement (Canadian Labour Congress, 1976).

Just cause. "Just cause" means well grounded, fair, equitable, and proper. If an organization is to discipline for "just cause" it is obliged, to satisfy in the final stage of the grievance procedure, that such "just cause" existed at the time of the handing out of the discipline. In other words, in a case of this kind the organization must establish affirmatively, the existence of grounds upon which it has chosen to act (Palmer, 1983, pp. 235-236).

Labour Relations Board. A board established under provincial or federal legislation to administer labour law, including certification of unions as bargaining agents, investigation of unfair labour practices and other functions prescribed under the legislation (Canadian Labour Congress, 1976).

Licensure. "The process of granting formal written permission from a constituted authority, in accordance with established requirements, to practice nursing" (International Council of Nurses, 1969, p. 37).

Litigation. "The act or process of engaging in legal action" (Funk & Wagnalls, 1974, p. 790).

Natural Justice. Administrative tribunals exercising a judicial or quasi-judicial function must adhere to the rules of natural justice: Audi alteram and nemo judex in sau causa. The audi alteram rule dictates that each party to a hearing has the right to: (a) have their case assessed in a fair and neutral manner by an arbitrator or board; (b) receive notice of the hearing; (c) obtain legal representation; and (d) cross examine witnesses. The neo judex in sau causa rule "requires the exclusion of all forms of bias from tribunal hearings" (Gall, 1983, pp. 287-288).

Suspension. A temporary cessation of employment. The suspension may be given with or without pay depending on the circumstances.

Organization of the Remainder of This Dissertation

The following chapter contains an overview on professionalism and competency in nursing practise as the background information for the study. In Chapter 3, the research methodology is presented. Chapters 4 through 6 are devoted to an examination of legal, arbitration and professional discipline cases. Specifically, Chapter 4 addresses the type of nurse behaviours which resulted in negligence lawsuits and the legal consequences of these behaviours. Chapter 5 contains a case review of the types of nurse behaviours which resulted in suspension and termination from employment and the arbitral consequences of these behaviours. In Chapter 6, the types of nurse behaviours which resulted in disciplinary action by the professional association are presented. A summary of the findings on nurse behaviours which resulted in disciplinary action is provided in Chapter 7. Operational definitions of negligence, incompetence, unskilled practise and professional misconduct based upon the legal, arbitration and professional discipline cases are also provided. In Chapter 8, the study purposes and procedures are reviewed and the findings of the study are presented in summary form. In addition, implications of the study are presented along with recommendations for employers, arbitrators, nursing associations, nursing unions, nurse practitioners, nurse administrators, and nurse educators.

Chapter 2

A REVIEW OF THE LITERATURE ON PROFESSIONALISM AND COMPETENCY IN NURSING PRACTICE

Introduction

The purpose of this chapter is to present background information related to professionalism and competency in nursing practise. This is done in two stages. First, an overview of the components of professionalism is provided in order to examine the degree to which nursing may be considered a profession.

Three statements which underline the importance of understanding professionalism are as follows:

1. If nursing is a profession, then nurses may be held liable for malpractise rather than negligence. The disciplining of nursing practice would be as with other professions: professional discipline and civil lawsuits (Picard, 1978);

2. If nursing is neither a profession nor a semi-profession but is a skilled or semi-skilled occupation, then nurses as employees in organizations where they are governed by collective agreements, would be subject to grievance arbitration and civil lawsuits; and

3. If nursing is a semi-profession, then nurses have employee as well as legal and professional

responsibilities and thus would be subject to grievance arbitration, as is the case with other occupations having collective agreements, to civil lawsuits, and to professional discipline.

The legal system may be described as an adversarial system in which the parties vie and maneuver in opposition to each other. That is, each party has the right to present evidence to support its own case and the right to cross examine witnesses who present evidence for the other party. The plaintiff and the defendant in the courts have a right to be heard by an impartial third party, a judge, who is responsible for taking into consideration all facts presented and then awarding a final judgement. Professional discipline, on the other hand, may be described as an inquisitorial system, or a judicial or official inquiry where colleagues or peers hear all relevant facts and put forth a recommendation to the council of the profession which then determines the nature of the discipline imposed, if any. The grievance arbitration procedure appears to contain elements of both an adversarial system and an inquisitorial system in that the "facts of the case" are presented by both the union and management and heard by an arbitration tribunal which renders a decision binding on both parties. Nurses appear to be in a somewhat unique position when compared with the "noble professions" on the one hand, and the semi-skilled occupations on the other, in that, like semi-skilled occupations, they may be subject to civil lawsuits and grievance arbitration, but like professions, their members may be subject as well to professional discipline. In addition, should criminal action be involved in nursing practice, as with any professional or non-professional occupation, the nurse involved could be subject to criminal lawsuits.

The second area to be examined in the literature review is responsibility, accountability and competency in nursing practise in order to provide a framework for examination of incompetency in nursing practise.

Lee and Sandroff (1984) address the uncertainties and challenges facing the health care system and nursing in their statement, "Nursing stands at the brink of disaster--or just a step away from professional fulfillment" (pp. 26-29). Lancaster (1986) asserts that:

> . . . nursing is at a crossroad in its development as an integral profession within the health care system. Critics contend that nursing has no unique body of knowledge, that graduates fail to meet the needs of employers, that we have no standard, generally accepted system for educating our members, and that our profession vacillates between open warfare and apathy. (p. 31)

Current nursing literature stresses that nurses must adapt to the changes prevalent in society and have a united and strong voice in shaping the social, economic, political and professional arena. The emerging trends which are expected to have a strong impact on nursing in the near future include: (1) an increase in the number of elderly utilizing various modalities of service, i.e., institutional care, home care, and outreach programs; (2) technological advancement particularly in regards to computerization; (3) changes in life-styles; (4) cost-containment of health services; and (5) legislative and court challenges to nursing practise (Andreoli & Musser, 1985; Carty & Bednash, 1985; Daria & Moran, 1985; Lancaster, 1986). In a recent article titled, "Trends that May Affect Nursing's Future," Andreoli and Musser (1985) offer the following insights:

> . . . for nursing to survive the increasing competition and stringent cost-containment measures at hand, and to enhance those clinical nursing skills that will be most valuable in the long run, nursing must respond with a plan that is timely, relevant, flexible, and feasible. The plan must include political strategies in practice, research, and education. (p. 49)

The areas to be addressed in the next decade, albeit not inclusive, by professional nurses are: public accountability and professional autonomy, political effectiveness, participation in research, entry to practise, credentialing and competency issues, and discipline of members. In the last several years, nursing scholars have debated vigorously over whether graduates of the future will be prepared sufficiently to perform tasks in a safe and competent manner especially within the context of a highly technological and stressful work environment. Concerned educators, administrators and researchers will be required to address the following questions: Is nursing a profession? How do we achieve autonomy in nursing practise? What is accountability? What constitutes competency? Who assesses whether an individual is competent--society, government, professional associations, patients, other members of the multi-disciplinary health care team, administrators, educators, or other nursing practitioners? What is the protocol for reporting an individual for incompetence/unskilled practise, professional misconduct? What avenues are open to those individuals who are deemed to be incompetent or found to be unsafe to practise?

The first topic to be addressed is whether nursing is a profession. First, a general overview of the components of a profession is presented. This is followed by an examination of specific components of a profession as it relates to nursing. The specific components reviewed are: a systematic body of knowledge, professional authority, community sanction, a code of ethics and the professional culture.

An Overview of the Components of a Profession

Definition of a Profession

A profession is defined as:

> . . . that which one professes or practices as a calling, specifically one of the learned or liberal vocations, formerly sharply contrasted with trade or business, though the distinction is rapidly breaking down: the learned scientific professions; the profession of a barrister; a doctor by profession. (Wyld & Partridge, 1968, p. 1127).

The earliest recorded reference to the concept of profession occurred in the 13th century and referred to the clergy. By the 16th century divinity, law and medicine were classified as the learned professions (Miller, 1985, p. 22). The members of the craft guilds were distinguished from members of the learned professions as follows:

> The members of the guilds had the competencies and skills of specialization which afforded them uniqueness and status while the learned professionals had the knowledge and education which gave the members the credentials of legitimacy. (Miller, 1985, p. 22)

During the 50's and early 60's sociologists described professionals as possessing a knowledge-skill base and a service ideal. As stated by Cogan (1953):

> A profession is a vocation whose practice is founded upon an understanding of the theoretical structures of some department of learning or science, and upon the abilities accompanying such understanding. This understanding and these abilities are applied to the practical affairs of man. The practices of the profession are modified by knowledge of a generalized nature and by the accumulated wisdom and experience of mankind, which serve to correct the errors of specialism. The profession, serving the vital needs of man, considers its first ethical imperative to be altruistic service to the client. (pp. 48-49)

This focus changed in the late 60's and 70's to include the "political influences of professions and the relations of the professions to the economics, and class systems" (Miller, 1985, p. 23). Hall (1982) contends that the relationship of professionals to their power in society will dominate future scholarly writing in sociology with an added proviso that the "nature of profession will remain a central interest for nursing" (cited in Miller, 1985, p. 23).

Millerson (1964) examined the scholarly works of 23 sociologists on the concept of profession and concluded that "of the dozens of writers on the subject few seem able to agree on the real determinants of professional status" (p. 15). In the sociological literature two models of professionalism were identified: trait models and functional models. Trait models comprise a list of attributes frequently used to describe a profession: (1) skill based on theoretical knowledge, (2) education and training, (3) a service ideal, (4) organization and autonomy, and (5) adherence to a code of ethics (Goode, 1961; Greenwood, 1966; Hall, 1968; Wilensky, 1964). According to trait theorists there are developmental stages inherent in the professionalization process:

1. the establishment of a professional association with a well-defined knowledge skill base;
2. the development of a code of ethics;
3. the development of a curriculum for educating students which undergoes changes as required;
4. the control and ongoing evaluation of training facilities; and
5. the formulation of legislation applicable to the practise of the discipline (Caplow, 1954, pp. 139-140).

Trait theorists have been criticized by their colleagues for failure to take into consideration: (1) historical factors, (2) social considerations, (3) the extent to which governments or society may impose definitions on the organization of the occupation and content of practise, and (4) the character of the clientele (Johnson, 1972, p. 30).

Functional theorists differ in their orientation by ascribing characteristics which exhibit community interest among the individuals within the occupation. Barber (1963) defines professional behaviour in terms of four characteristics: (1) a high degree of generalized and systematic knowledge, (2) primary orientation to the community interest rather than to the individual self-interest, (3) a high degree of self-control of behaviour through a code of ethics internalized in the process of work socialization and through voluntary associations organized and operated by the work specialists themselves, and (4) a system of rewards (monetary and honorary) that is primarily a set of symbols of work achievement and thus ends in themselves, not means to some end of individual self-interest (p. 672).

The Components of a Profession As It Applies to Nursing

In the nursing literature reviewed, it is apparent that nursing has devoted a great deal of time to the topic of whether nursing is a profession (DeSantis, 1982;

Melosh, 1982; Miller, 1985; White, 1984). Etzioni (1969) characterized nurses, teachers and social workers as semi-professionals for the following reasons:

> One, their training is shorter. Two, their status is less legitimized. Three, their right to privileged information is less established. Four, there is a less specialized body of knowledge, as evidenced by the different educational programs. Five, they have less autonomy from supervision or societal control than the true profession. (Cited in Schriner & Harris, 1984, p. 253).

Melosh (1982) in her book titled, "The Physician's Hand: Work Culture and Conflict in American Nursing," states emphatically, ". . . nursing is not and cannot be a profession" (p. 1). This may seem a rather strong statement, however, it must be noted that Melosh rejects the attributes espoused by sociologists, for example, autonomy, specialized knowledge, independent judgment, code of ethics, service orientation and focuses upon social power as a measure of professional status (Doona, 1984, p. 135). Her study encompasses labour history, feminist history, social history and nursing history and concludes that "gender, class, and race impede nursing's quest for professional status" (Doona, 1984, p. 23).

Styles (1982) also focuses upon social power as influencing professional status. In a term coined, "professionhood," Styles elaborates on three critical attributes:

1. A sense of social significance regarding nursing and ourselves;
2. Commitment to ultimacy of performance in our work; and

> 3. The twin attitudes of collegiality and collectivity. (p. 18)

Stinson (1969), a nursing scholar in Canada, suggests that nursing was in the process of professionalization in the early twenties:

> The configuration of characteristics in nursing c. 1920 constitutes evidence that nursing was undergoing a process of professionalization at that time, the central reasons: (1) the related substance of the knowledge-skill component, (2) the existence of a well-integrated professional culture, (3) the substantial articulation of nursing roles with those of related health personnel, (4) the nursing practitioner had a high degree of functional autonomy, and (5) advancement in nursing was largely co-terminal with advancement in technical expertise in nursing. (p. 378).

During the sixties, nursing entered into a period coined by Stinson as "dysfunctional deprofessionalization" in which there was:

> . . . deterioration of the substantive knowledge skill component, a decline in the aura of mystery, lack of theoretical development, and inadequate development of methodology suitable to research in nursing. (p. 378)

In order to determine whether nursing is evolving as a profession and will be held liable for negligence or malpractice in the future, the components of a profession as presented in the nursing literature will be examined. The components to be examined include:

1. a systematic body of knowledge;
2. professional authority;
3. community sanction;
4. a code of ethics; and
5. the professional culture.

A systematic body of knowledge. Kellams (1977) states "that nursing's claim to autonomy must ultimately rest on developing and disseminating knowledge that is unique to nursing and to provide services in the interest of the public" (pp. 30-31).

Conway (1983) states:

> A task to which nursing as a professional body must devote its greatest efforts over the next several decades is the development of a knowledge base for its professional practice. For nursing, as in every other learned discipline, its knowledge base is the *sine qua non* for its claim to professional status. This knowledge base will consist of a body of theoretical formulations derived from the generation and repeated testing of hypotheses and the application of findings from these tests to practice under carefully monitored and controlled conditions. (p. 33)

Conway does not imply that nursing theory is nonexistent, however she feels it is still in a "rudimentary stage and has not been subjected to systematic testing" (Conway, 1983, p. 34).

Greenwood (1966) offers further insights into the development of a body of knowledge unique to nursing:

> The skills that characterize a profession flow from and are supported by a fund of knowledge that has been organized into an internally consistent system called a body of theory. A profession's underlying body of theory is a system of abstract propositions that describe in general terms the classes of phenomena comprising the profession's focus of interest. Theory serves as a basis in terms of which the professional rationalizes its operations in concrete situations . . . to generate valid theory that will provide a solid base for professional techniques requires the application of scientific method to the service-related problems of the profession. Continued employment of the scientific method is nurtured by and in turn reinforces the element of rationality . . . . The spirit of

> rationality in a profession encourages a critical, as opposed to reverential, attitude toward the system. It implies a perpetual readiness to discard any portion of that system, no matter how time-honoured it may be, with a formulation demonstrated to be more valid. The spirit of rationality generates group self-criticism and theoretical controversy. Professional members convene regularly in their associations to learn and to evaluate innovations in theory. (p. 12)

Adam (1985) reviewed several conceptual frameworks, theories and models developed by nurses and suggests that one of the major problems is confusion surrounding terminology used in nursing practise, research and education. She concludes:

> Nurse authors do not agree that nursing theory exists, that nursing has its own body of knowledge, that nursing is a science or even a discipline. Yet nursing is fully equipped to justify its claim to such terms. Starting from a nursing perspective rather than from a borrowed one, nursing theory can be developed, nursing knowledge can be accumulated, and nursing science can be advanced, all in the interests of a worthwhile contribution to society's health. . . . If indeed for nursing to be recognized as a science (and as a profession) it must have a body of knowledge, if to have a body of knowledge there must be theory development; if to develop theory one must begin at the first level of factor isolating; if factor isolating cannot be done except from a broad perspective; nursing is in an enviable position of having broad perspectives, conceptual models for practice, any one of which provides a conceptual departure point for practice, research and education. Nursing is prepared to justify the claims of those who already refer to nursing theory and science. At the same time it offers a distinct and explicit service to society, nursing is equipped to move forward to leadership in the health arena. Rather than explaining and excusing the confusion in terminology, educators face the challenge of helping students to learn the intellectual excitement of a strong commitment to nursing. (pp. 151, 155)

If nursing is to evolve from the status of semi-profession to profession, a very positive, action-orientated approach must be taken by nursing educators, administrators, practitioners and researchers to develop and advance a body of knowledge which distinguishes nursing from other professions. One of the primary concerns of nursing educators is to teach nursing students the fundamental skills of nursing research and the importance of publishing their findings (Diers, 1986; Duffy & Halloran, 1986; Miller, 1985; Lancaster, 1986; Rawnsley, 1978). As pointed out by Conway-Rutkowski, "the point at which theoretical formulations, that is, generalizations are systematically applied to practice is the critical end state for nursing" (1984, p. 34).

Therefore, in order to develop a strong knowledge base, nurses must be prepared to apply the concepts of theoretical models in the practise setting and to publish findings in scholarly journals. The second component to be explored is professional authority, the ability to present the image of the profession as being strong, dedicated, knowledgeable, trustworthy and able to clearly articulate to other health care professionals, consumers and politicians exactly what it is that nurses do.

Professional authority. Professional authority is defined as a "system of control in which power is vested in the members of the professional group rather than an individual, and spoken of as collegial authority" (Sargis, 1978, p. 23).

Greenwood (1966) contends that:

> . . . extensive education in the systematic theory of his discipline imparts to the professional a type of knowledge that highlights the layman's comparative ignorance. This fact is the basis for the professional's authority. (p. 12)

Professional service is by its very nature unique (Gross, 1958, p. 77). The provision of a service which cannot be prescribed in advance requires a relationship of trust and respect between the practitioner and the consumer. Sussman (1965) states:

> The professional . . . does not wish to be governed in his relationship by the "caveat emptor" of the market place. He prefers "credat emptor," a fiduciary relationship of mutual trust in which the client places his case fully and completely in the hands of the professional, and, in return the professional is given the freedom to act on the merits of the case without being judged except by his colleagues. (p. 187)

Today, consumers of health care are becoming more concerned about the quality of care they receive, their "rights" in a health care setting, the costs of health care services, extra billing, shortages of manpower, consumer product safety, drug safety, occupational health and safety, and the effects of the environment on their health. No longer are consumers willing to stand by and put their trust fully and completely in the hands of the professional. Fleming (1983) speaks to this issue:

> . . . society is, perhaps moving to an era where emphasis on patient involvement in care necessitates that the consumers have the essential role in his or her own care. . . . Health is important and the consumer is generally motivated to actively seek information if there is an impairment of health. The assumption that the nurse is a better judge of what

> is happening would place the nurse in an authoritative situation. . . . Consumers want health professionals who:
> (1) are dedicated and committed and who care about those to whom they give the care;
> (2) are competent and have the appropriate knowledge and skills to whom they give the care;
> (3) are aware of cultural differences among consumers;
> (4) speak and use language the consumer understands;
> (5) take time to explain care and problems associated with care;
> (6) treat the consumer with dignity and respect;
> (7) listen to consumer concerns about problems of care and management;
> (8) help the consumer evaluate the significance of certain symptoms; and
> (9) demonstrate to the consumer the appropriate self-care techniques. (p. 475)

It is generally understood that consumers "have a limited understanding of nurses' educational preparation, the scope and range of their services, or their ability to make effective changes" (American Nurses Association, 1980). Weiss (1984) cautions the nursing profession:

> As nurses, we must be able to clarify and assert our existing spheres of practice as well as those emerging spheres which we are best prepared to manage by reason of our unique expertise. If we cannot, the scope of nursing practice will be narrowly defined by others and nurses' unique skills will continue to go unrecognized . . . equally as important as the ability to articulate the nursing domain is one's ability to convey a nursing image conductive to expanded authority and responsibility. (pp. 10-11)

Lancaster (1986) suggests that in order to develop specialized knowledge, and freedom and authority to make judgements, nurses must:

> 1) Continue to support strong, visible leaders who can speak for and about nursing both within and outside the profession . . .,
> 2) Be competent as professionals, knowledgeable in ways that will influence the political process, and assertive as individuals, and

3) Learn to compete for research and other types of grant monies. (p. 36)

De Santis (1982) suggests that "political as well as professional skills are required" (p. 17) and that nurses need to convince the audience that:

> . . . that the occupation is providing a professional service that no one else can provide nearly as well. . . . The tactics involved in achieving the attributed characteristics require that reports be issued to interested bystanders proclaiming the findings of research being conducted by members. . . . Another characteristic involves providing a service to society that is closely related to a core value, in this case, the value is health. Society must be convinced that the occupation is promoting the good of society. The tactics might include: raising the standards for entry into the occupation so that only the best candidates will be accepted; advocating more health education for the public, which nursing would be willing to provide and supporting the reduction of health care costs by offering to develop less expensive forms of health care services. (pp. 17, 24)

In other words, nurses must continue to develop their "professional image," and their responsibility and accountability to the public. Ashley (1975) in her article titled "Power, Freedom and Professional Practice in Nursing" states:

> Nurses individually and collectively must increasingly arrive at the conclusion and connection that it is morally right for them to seek power, freedom and recognition . . . society will not frown upon our quest for power if we can justify our efforts in moral and ethical terms. The control of nursing's destiny and the development of professional practice depend upon a clear presentation of our motives devoid of the confusion, the misconceptions, and the fears so often accompanying the efforts of groups to obtain their freedom. Nursing administrators, supervisors and individual practitioners must continually explain to the public that we do not intend to use power to do harm to patients or to increase the cost of health care.

> There is ample evidence, if we would use it, to indicate that freeing nurses to practice as professional nurses improves care and can even cut down on the cost of care. (p. 19)

In sum, nurses must convey an image that projects a strong educational component, authority, respect from other professionals and the public and they must utilize their political skills to enhance health care even in a period of cost restraint. The third component to be reviewed is community sanction.

Community sanction. Every profession "strives to persuade the community to sanction its authority by conferring upon the profession a series of powers and privileges" (Greenwood, 1966, p. 13).

One of the powers granted to the profession is control of its education. In the field of nursing, the profession usually through its professional association:

> . . . establishes and enforces standards of education through accreditation of schools, provides opportunities for students to gain field experiences, and admits entrants into the profession only on the basis of certain standards which can be met by graduation from approved schools. (Monnig, 1983, p. 39)

As early as 1901 at the International Council of Nursing, Fenwick clearly urged nurses to obtain a university degree:

> I claim that the time has come when nurses will need their educational schools, their endowed colleges, their chairs of nursing, their university degrees and state registration; and the present seems the psychological moment to go to the public, not as strangers, but as professional workers known and trusted through the length and breadth of the land,

> and to urge that nurses pour out, on its behalf a skill of devotion for which gold is no recompense, the public shall now prove its appreciation and interest by giving something of its wealth to place nursing education and the status of the trained nurse on a strong financial basis. (Bridges, 1967, pp. 20-21)

The struggle continues today, almost 90 years since these words were spoken. One of the most debated issues in the last decade and one that has divided the profession as no other has been the "entry into practice issue" (Greenlaw, 1985, p. 120). Ehrat (1981) states the problem in a single question:

> What skills--cognitive, affective, psychomotor--are required for a product of the nursing educational system in order to competently perform nursing functions? (p. 487)

The Canadian Nurses' Association has resolved that by the year 2000, the minimal educational requirement for entry into the practise of nursing should be a baccalaureate degree in nursing (Canadian Nurses' Association, 1982). As outlined in the background paper titled, "Entry to the Practice of Nursing," the baccalaureate program should contain the following features:

1. A solid basis in the physical, biological and social sciences, nursing as a discipline including nursing research and ethics.
2. Emphasis on "Caring to Know--and Knowing to Care" (Diers, 1982).
3. Emphasis on all aspects of health promotion, generation development protection; maintenance and restoration, and on palliation.
4. Emphasis on critical thinking skills in relation to effective problem-solving; ethical decision-making; clinical practice evaluation; and application of nursing research to practice.

> 5. Emphasis not only on the nursing of individuals and families but also groups and communities, multicultural populations, and within a variety of contexts: institutions, workplaces, school, home.
> 6. Emphasis upon promoting self-care; and working with other professional and lay groups.
> 7. Emphasis on flexibility and competence in "learning how to learn" specialized knowledge and skills.
> 8. Knowledge of health care policy dynamics and of the basics of resource allocation.
> 9. Emphasis on the professional imperatives of integrity, knowledge, service to society, continuous learning, and accountability for one's actions. (Canadian Nurses' Association, 1982, p. 30)

Gallop (1981) describes the process of entry into practise in the Canadian context. She cautions nurses that if they utilize articulation, defined as building upon previously learned content, then they will once again create a different type of nurse, the generic baccalaureate nurse and the articulated baccalaureate nurse (p. 61). She advises:

> Articulation may undermine the very concept of a professional discipline approach. Integrity of curriculum is compromised by the need to adapt to lower level experiences and to semi-professional training based on non-baccalaureate objectives. It is an attempt to correct nursing's past errors in the educational process. The time for nursing education to be rooted in the university is long overdue. Nursing will benefit greatly from a 'unified' and professional discipline approach. (p. 62)

Richardson (1986) refutes Gallop's argument that articulation may undermine the concept of a professional discipline approach:

> In several Canadian provinces articulated baccalaureate nursing education programming is one viable mechanism for working toward baccalaureate entry to practice. Downward program planning for

> articulation can ensure quality of education in articulated baccalaureate programs. . . . Such articulation could occur in the Atlantic provinces, Manitoba, Alberta and British Columbia. (p. 56)

The entry into practise issue has been vigorously debated by several nursing scholars (Anello, 1981; Ehrat, 1981; Gallop, 1981; Partridge, 1979a; Richardson, 1986; Schaefer, 1980; Wooley, 1984). Schaefer (1980) poses the following questions:

> Can we bury the artificial barrier of "technical" versus professional education? Can "nursing" educators from the various levels of educational programs develop a cosmopolitan view of nursing and nurses, and work together on innovative admission policies for RN's seeking a baccalaureate degree, so that the policies preserve excellence and yet acknowledge the unique knowledge and experiential base each RN brings with her? . . . Are we willing to get our act together on the tremendous challenges that lie before us as health providers within the health delivery system? (p. 16)

It has been stated that "actions speak louder than professional words" (Williamson, 1983, p. 69). The mandate has been established by the professional association--the baccalaureate degree will be the entry point for practise by the year 2000. Theoretically speaking, this is the ideal. The reality, various inputs and their associated actors, as described in Anderson and Gunderson's (1982) model of the industrial relations system, will have an effect on the implementation of baccalaureate education by the year 2000. It is envisioned that the legal, economic, political and socio-cultural environment will have a dramatic impact. Practitioners, nursing unions and the government have already voiced their concerns and in one province, New Brunswick, a motion was passed by the members defeating baccalaureate education as the entry to practise and other provinces may follow suit. In the province of Alberta, the government has openly opposed this endeavour on political and economic grounds. The next few decades will be challenging and thought provoking as nurses search for solutions to this multi-faceted issue that has indeed divided the profession. Williamson (1983) in her article titled, "Crisis in Academic Nursing," offers insightful comments in regard to entry into practise, and graduate programs at the master's and doctoral level. She proposes: (1) that diploma programs in hospitals be phased out; (2) that the content of an associate degree be redefined to a narrow sphere of technology, such as the intensive care units; and (3) that the baccalaureate degree be renamed the baccalaureate degree in nursing technology (p. 67). The master's degree would prepare nurses in a specialty area and graduate work at the doctoral level would prepare nurses for research (Williamson, 1983, pp. 67-68).

It is important to note that other occupations such as teachers, engineers, occupational therapists, physiotherapists and pharmacists have as their entry to practise a baccalaureate education. If nursing desires to evolve as a profession, then a key component would seem to be the acquisition of a baccalaureate degree. The entry to practise dilemma will require ongoing thoughtful deliberations by governments, professional associations, nursing unions and practitioners at all levels.

The second power granted to professionals by the community is a licensing system. Hughes (1958) has expressed the relationship between the profession and society in terms of "license and mandate" (p. 78). Through licensing, "competence becomes an attribute of the profession as a whole, rather than of individuals as such" (Hughes, 1958, pp. 141-142). The public and the profession are protected "by the fiction that all licensed professionals are competent and ethical unless found otherwise by their peers" (Hughes, 1958, pp. 141-142). The concept of competency in nursing practise will be reviewed later in this chapter. The terms licensing and mandate deserve further clarification. As pointed out by Monnig, a paradox exists between licensing regulations and the state. She contends that:

> . . . the profession is independent of the state is explicit in licensing requirements. The profession serves a public interest which the state may reasonably regulate. The public sees the profession subservient to the state because there is regulation, but the paradox is that the agency of regulation is self-regulation by the profession. (Monnig, 1983, p. 42)

The term mandate refers to "authoritative command" (Funk & Wagnalls, 1983, p. 822). Hughes refers to the fact that:

> . . . professions, perhaps more than other kinds of occupations, claim a legal, moral, and intellectual

> mandate. Not merely do the practitioners, by virtue of gaining admission to the charmed circle of colleagues, individually exercise the license to do things others do not, but collectively they presume to tell society what is good and right for the individual and for the society at large in some aspects of life. (Hughes, 1958, p. 79)

Hughes suggests that the mandate of the professional may go further than "successful insistences that other people stand back and give the worker elbow room but may delve into the domain of controlling the tasks of others in the work situation" (Hughes, 1958, p. 79). Sussman states that:

> . . . autonomy comprises control of functions in the work situations . . . to the extent that society has confidence in the occupation service orientation, it will grant autonomy in defining tasks and practices as both safe and necessary. (Sussman, 1984, pp. 184, 207)

In the nursing profession, nursing practise acts "set forth educational and examination requirements; provide for registration of the professional" (Monnig, 1983, p. 41); and also provide an avenue whereby members may be disciplined. Prowse (1983) presents an overview of legislation governing nursing practise in her paper titled "Nursing Legislation in Canada: An Overview for Health Services Administrators," although her discussion on professional discipline is rather limited.

The nursing profession, in its quest for professional identity has yet to achieve autonomy, defined as the right of self-determination and governance without outside control (Maas, 1976, pp. 35-36). Christman (1976), an author and educator in nursing, contends that nurses should have parity with the medical and administrative staff, thus freeing them from hierarchical controls, requirements for consultation, and excessive supervision (pp. 37-44). He believes that nurses should have direct relationship to and responsibilities for their clients. This concept has been difficult to put into practise, since in order to achieve autonomy, nurses must operate independently from the physician (Freidson, 1970, pp. 63-66). Singleton and Nail (1984) suggest that "before autonomy in nursing practice can become a reality, nurses must clearly identify their roles" (p. 17). Several nursing scholars have addressed role clarification as of primary importance in the movement towards autonomy and power (Bernardo, 1984; Goad & Moir, 1981; Dieman & Russell, 1984; McKenna, 1981; Schriner & Harris, 1984; Singleton, 1984; Vance, 1985).

In summary, a strong educational base at the university level, a licensing system regulated by the profession, and autonomy and self-governance are requirements if nursing is to establish itself as a full-fledged profession. The process of achieving an entry into practise which is acceptable to members and the movement towards autonomy is likely to be extremely complex and require thoughtful deliberation by nurses at all levels. In addition, cooperative efforts between professional associations, nursing unions, other professional associations and the government will be required. Of particular note is the fact that the professional association may set standards for entry into practise. However, in reality, members by utilizing various modalities such as the union and/or political action may refute the concept.

The next component to be explored is a code of ethics. Philpott (1985) states:

> Once a code of ethics is adopted . . . each member . . . is expected to regulate his or her practice accordingly and can be held accountable through the disciplinary arm of the profession for infractions of the adopted code of ethics. (p. 162)

A code of ethics. The importance of a code of ethics cannot be overstated since an individual may be judged on infractions:

> A profession's code of ethics is the yardstick against which society and the courts measure the actions of individual members of that profession. Once accepted, a code of ethics soon becomes entrenched in tradition and rapidly acquires an aura of ethical absoluteness that determines the ethical parameters of professional actions. (Kluge, 1982, p. 34)

The nursing profession has developed a code of ethics in the following jurisdictions: Alberta, Manitoba, Newfoundland, Ontario, Prince Edward Island, Quebec, and Saskatchewan (Prowse, 1983, p. 57). The Canadian Nurses' Association recently adopted a code of ethics, however Kluge has cautioned nurses to avoid the use of caring and commitment when "trying to spell out the ethical parameters" as these terms only "serve to cloud the issue of where--and how--the limits of ethical obligation are to be drawn (Kluge, 1982, p. 36). Curtin (1985b), in an address to the Alberta Association of Registered Nurses, alerts nurses:

> To develop a professional ethic, we must first consider what being a professional means. Then we have to study the origins of ethics and ethical principles, and finally we put these concepts together to determine what our duties, our rights, and our privileges are as practitioners. (p. 1)

Control over professional actions is not only achieved through a formal code of ethics. Professional actions are vested primarily in an internalized and self-imposed code of professional behaviour, and this self-discipline is supported by the external surveillance of one's conduct by the peer group (Blau & Scott, 1962, p. 63). Following a lengthy period of training and socialization, the professional is expected to have an internalized code of ethics which governs his conduct. Hughes (1958) states:

> The training . . . carries with it as a by-product assimilation of the candidate to a set of professional attitudes and controls, a professional conscience and solidarity. The professional claims and aims to be a moral unit. (p. 102)

Informal discipline "consists of the subtle pressures that colleagues exert upon one another" (Greenwood, 1957, p. 15). Formal discipline is:

> . . . exercised by the professional associations, which possess the power to criticize or to censure, and in extreme cases to bar recalcitrants. Since membership in good standing is a sine qua non of professional success, the process of formal disciplinary action operates as a potent force toward

conformity. (Greenwood, 1957, p. 16)

Every jurisdiction in Canada has a formal procedure to discipline those members of the nursing profession who do not conform. The procedures vary from province to province and this process will be described in more detail in Chapter 6. Cohn (1983) in an article titled, "Revocation of Nurses' Licenses: How Does It Happen?" states that a nurse's license may not be revoked arbitrarily. Grounds for revocation of license include: (1) improper procuring of license or criminality; (2) physical or mental incapacity; (3) unprofessional conduct or misconduct; and (4) incompetence, negligence and malpractice (Cohn, 1983, pp. 22-24).

The final component to be examined is the concept of a professional culture.

The professional culture. Carr-Saunders and Wilson (1964) in their study on the evolution of professions observed that one of the first attempts made by practitioners is the formation of a professional culture. They conclude:

> The history of the evolution of the profession brings a significant fact to light. As soon as the profession emerges, the practitioners are moved by the recognition of common interests to attempt to form a professional association. (p. 5)

Carr-Saunders and Wilson also maintain that the reasons why practitioners form an association are: (1) to ensure that a service of the highest quality is provided to the public, (2) to obtain recognition of its status in the larger society, (3) to ensure that members are competent, and (4) to raise levels of remuneration (Carr-Saunders and Wilson, 1964, pp. 3-9). Rowsell (1980) outlines the major roles and responsibilities of the professional association and union (pp. 44-45). These are presented in Figure 2.1.

Rowsell maintains that the major responsibility of the union is to advance the socio-economic welfare of its membership whereas the professional association's mandate is to improve practise standards.

The researcher and a colleague (Conroy & Hibberd, 1983) in an article titled, "Areas for Cooperation and Conflict between Professional Associations and Negotiating Bodies," indicate that both the professional association and the union play a significant role in the socio-economic welfare of nurses. We note that the primary role of the association is "to promote and maintain the highest standards of professional nursing care to the public, whereas, the primary role of the union is to promote the economic welfare of nurses" (p. 83). In Canada, the nursing association does not represent the socio-economic welfare of nurses. Rowsell (1980) explains the reasons for this:

> In most cases, the professional association in each province could not achieve certification as the appropriate bargaining agent for its members because of conflict with existing legislation [the only exception is Prince Edward Island which does not have

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NURSES UNIONS have now assumed the major responsibility for advancing the socio-economic welfare of the members they represent--approximately 85,000 across Canada. "The prime responsibility of these unions is to regulate regulations between the employees and employers through:

- negotiating collective agreements providing particularly for improvements in salaries, hours of work, medical welfare benefits and working conditions
- promoting and understanding of administration of collective agreements
- processing grievances including grievance arbitration
- educating members in the area of labor relations and labor legislation
- assisting members with problems arising in a work setting related to the practice of the nurse's profession
- communicating with its members, professional associations, government and general public
- promoting and maintaining professional standards of care as developed by the professional nurses associations
- striving to improve practice settings to allow for the achievements of these standards
- ensuring fair representation of all the employees under the jurisdictions of the unions
- protecting the health and safety of nurses in their working environments.

Most registered nurses who belong to a union are also members of their provincial/territorial professional association. Not all union members are registered nurses, however, since under the terms of their certification some unions are required to represent graduate nurses.

One of the major roles of **THE PROFESSIONAL ASSOCIATION** is the improvement of practice through standards of selection, preparation and performance of practitioners. It is usually the licensing authority with the right to discipline members who do not meet acceptable standards of practice. It meets the needs of the public and its members by:

- providing and influencing continuing education programs for nurses
- ensuring competency to practice
- presenting an informed voice to effect change
- acting as spokesman for the nursing profession with government and other organizations and groups
- protecting the safety of the public
- seeking desirable changes in legislation
- promoting research and studies in nursing
- communicating with members through meetings, conferences, newsletters and the media
- collaborating with other health organizations engaged in health care
- developing social and economic welfare programs for its members
- developing a code of ethics to maintain standards of performance
- encouraging its members to develop new and improved skills to retain and improve their knowledge and practice.

All provincial/territorial nurses' associations are members of the Canadian Nurses Association and the International Council of Nurses; each level of organization supplements the other by extending its sphere of influence.

Figure 2.1

A Comparison of the Roles and Responsibilities of Professional Associations and Nursing Unions (Source: Rowsell, 1980, p. 45. Reproduced with permission from The Canadian Nurse.)

> collective bargaining rights under the Nurses' Act of PEI]. In Canada, laws governing collective bargaining are under the jurisdiction of both the provincial/territorial and federal governments. These Acts are administered by the Labour Relations Board in each province which also determines the level of employees eligible to become members of the bargaining unit. In determining the appropriate unit, each board must comply with the definition of employee described in its provincial act. Nursing classifications included in provincial bargaining units therefore differ from province to province. The fact that some of their members were classified as management meant that professional associations, for the most part could not qualify under the Labour Act to serve as bargaining agents. To bargain without the protection of the Labour Act was unthinkable since employers, faced with such a situation could simply refuse to negotiate. Thus nurses found themselves coming under the definition of a trade union as determined by existing labour legislation. (p. 44)

This does not imply that the professional association is not interested in the socio-economic welfare of its members. Conroy and Hibberd (1983) elaborate on this point:

> Even though the professional association may have no legal role in collective bargaining this does not mean that the professional association ceases to be interested in the economic status of its members. The leading argument justifying the involvement of professional nursing associations in collective bargaining was, and still is, that salaries and terms of employment for nurses must be maintained at sufficiently high levels to attract new recruits into the profession. (p. 83)

Several nursing scholars have discussed the conflicting demands of professionalism and unionism (Baumgart, 1983; Foucher, 1980; Jensen, 1981; Lemieux-Charles, 1980; Reeder, 1983; Yeager & Kline, 1983). These authors as well as the researcher and a colleague (Conroy & Hibberd, 1983) concur that professionalism and collective bargaining are compatible, however there are specific areas in which there is potential for conflict between the two parties. The areas in which potential conflict could develop are strikes, entry to practise issues, and discipline.

In summary, based on the literature reviewed, it would be reasonable to conclude that the practise of nursing has yet to achieve the standing of a full-fledged profession. At present, the nursing body is best described by the various writers as a semi-profession or a quasi profession since two essential components have yet to be developed: a knowledge skill base unique to nursing and autonomy. It has been suggested by several scholars that nurse educators continue to teach the fundamental skills of nursing research and the importance of publishing findings in order that the knowledge-skill base may be further developed and refined. In terms of professional authority, it is imperative that nurses convey an image that projects a strong educational component, authority, and respect from other professionals and the public. It is also important that nurses convey to the public exactly what it is that they do.

Nursing has already developed a licensing system, a code of ethics and a professional culture. However, the extensive writings on the topic would lead us to the generalization that there are several concerns that specifically need to be addressed: entry to practise, autonomy, role clarification, competency issues, discipline and the conflicting demands of professionalism and unionism. The nursing profession is deemed to be strong and able to achieve its potential as a profession if nurses are willing to present a unified approach to the problems plaguing the field. Of particular note is the strength the unions are achieving as a result of having the power to enforce nursing standards in health care settings, i.e., staff/patient ratios, unsafe patient care, scheduling and workload indices. In order to achieve professionalism in its truest sense, the union and professional association must adopt mechanisms whereby there is cooperation between the organizations, especially as it relates to discipline of members. The complexities involved in the discipline of nurses cannot be overstated. In the final analysis, nurses are held responsible and accountable for their actions. Nurses are expected to provide care to patients in a safe and competent manner.

The second topic to be addressed in this chapter is competency in nursing practise. This is done in order to provide background information for the reader on the area of incompetency. First, a general introduction to the discrepancy that exists between education and practise is reviewed. Second, competency is defined. This is followed by a general overview of the literature on competency in nursing as it relates to student nurses, nurse practitioners, nursing administrators and clinical nurse specialists.

Competency in Nursing Practice

Introduction: The Discrepancy between Education and Practice

MacPhail (1976) in an article titled, "Promoting Collaboration between Education and Service," addresses the lack of preparation a student nurse has for entry into the practise of nursing. As stated explicitly:

> In the past, the modus operandi in nursing settings tended to engender rigidity, conformity, dependence on rules and regulations and superiors, and adherence to long-standing patterns that lacked established scientific bases. These conditions prevail in some nursing settings today. Such an environment is antithetical to the mission of educational programs that should be promoting the development of habits and mind that will be useful in dealing with new situations. These habits of mind include curiosity, openmindedness, objectivity, respect for evidence, ability to think critically, flexibility, tolerance of ambiguity, independence of thought and action, and responsibility for continued learning. (MacPhail, 1976, p. 19)

Lancaster (1984) concurs with MacPhail and points out the need for collaboration between educators and practitioners in conducting research-related activities. She states:

> . . . Nursing has, for decades, experienced divisiveness between practice and education. . . . Research offers a mechanism for nurses to move beyond an "if it weren't for you attitude." As these groups mutually identify nursing care problems, develop methodologies for examining alternatives or actions, and carry out and analyze research results, they tend to understand one another's world and one another's problems better and to realize that there is much more to gain by working with rather than against each other. (p.379)

These authors point out one of the major problems that exists in nursing today--the discrepancy between practise and education. Bolton (1984) cites one of the reasons for this discrepancy is that many programs "deemphasize clinical skills" (p. 385). Other nursing scholars have pondered whether nurses in the future will be prepared sufficiently to practise in a competent manner to meet the ever-increasing demands of a highly technological environment where skill and judgement will be required in life-threatening situations (Blanchard, 1983b; del Bueno, 1978; Field, Gallman, Nicholson & Dreher, 1984; Flaherty, 1982; Ignatavicius & Naumann, 1986; Lancaster, 1984; MacPhail, 1976). The purpose of this section is to present an overview of the literature on competency in order to provide a framework for understanding the complexities of the continuum which exists between competency and incompetency.

An Overview of the Literature on Competency in Nursing Practice

Competency Defined

Competence is the ". . . ability to meet or surpass prevailing standards of adequacy for a particular activity" (Butler, 1978, p. 7).

Swendsen Boss (1985) states that competency not only includes ". . . job related skills but also a well-rounded education that teaches students to apply integrated theories in a critical, scientific framework" (p. 8). She believes that:

> Values, critical thinking, clinical judgement, formulation of attitudes, and integration of theories from the humanities and sciences into the nursing role are also competencies. (Swendsen Boss, 1985, p. 8).

The term "competency-based" has been utilized to describe educational practices, administrative practices, research activities and orientation programs. Confusion exists about what it is and its usefulness in teaching students, practitioners and administrators to be competent. Advocates in the education setting see competency-based education as a "cure-all for past educational practices" (del Bueno, 1978, p. 10). The concept has been introduced in a variety of educational settings and practise settings and has met with a varied degree of success (del Bueno & Altano, 1984, p. 48). First, the concept of competency-based education will be examined. This will be followed by a discussion of competency-based practise.

Competency-Based Education

Del Bueno (1978) describes competency-based education as:

> . . . a very broad concept that is used as the conceptual framework for a total curriculum, or it can be interpreted in a very narrow way, as a framework for an individual unit of instruction such as a learning module. The broad interpretation allows the learner to be totally self-directed in the selection of: (1) objectives and goals; (2) learning experiences; and (3) methods of evaluation used to demonstrate achievement of the goals. (p. 10)

Basically, competency-based education includes:

1. the identification of skills required in the practise setting;

2. the provision of learning experiences in order that an individual may meet the established standards; and

3. the assessment of whether the individual has met the standards of practise in a safe and competent manner Swendsen Boss, 1985, p. 8).

Competency-Based Practice

Dick (1983) in an article titled, "What Makes an Excellent Practising Nurse?" discusses four elements of excellence:

> 1. Practice should be based on a well-defined practice model and an internalized value system that respects the dignity of each individual.
> 2. Commitment to scholarship and research is necessary to create new knowledge and validate practice.
> 3. Each nurse functions simultaneously as expert clinical practitioner, educator, researcher and clinical practice manager.
> 4. Nurses must continue to learn in order to maintain their skills and prevent professional obsolescence. (pp. 44-45)

Excellence in nursing practise according to Dick (1983) means that:

> . . . a nurse is so committed, so energetic, and dedicated that she must practice, she cannot think of a life that does not include practising nursing. She is scholarly in the sense that she knows what questions to ask to resolve problems in nursing care and to advance nursing practice. In addition, she is able to teach patients and other nurses. She exhibits a drive to practice by her energy and enthusiasm for nursing. (p. 45)

The foregoing discussion by Dick is familiar to practising nurses regardless of what setting or specialty area they work in. Each one strives to be accountable, committed, caring, dedicated and competent and in the real world with all the environmental, political, economic and social factors present, however, the road ahead to "be all things to all people" is not an easy one. There are incongruencies as to what a diploma nurse versus a nurse with a baccalaureate should be doing. Yet, in reality all nurses carry the title, registered nurse. Is a nurse with a baccalaureate more competent that a nurse with a diploma?

Competency-based practise will now be described with particular focus on literature relating to the competency of student nurses, nurse practitioners, nursing administrators and clinical nurse specialists.

Competency of student nurses. The literature relating the competencies of student nurses differentiates between three types of nurses, the baccalaureate, referred to as the professional nurse; the associate degree nurse, a community college graduate and the diploma nurse. The associate degree nurse and diploma nurse are both referred to as the technical nurse. Johnston (1982) provides a clear definition for both categories:

> Professional nursing: that practice by a registered nurse whose highest earned degree was a bachelor of science in nursing (BSN).

> Technical nursing: that practice by a registered nurse who is a graduate of an associate degree in nursing (ADN) or diploma program. (p. 376)

In Canada, a similar structure exists, however, a comparison between professional and technical has not been noted in the literature. At present, there are various entry levels to nursing programs in Canada: a 2, 2 1/2, or 3 year hospital based program, a 2-2 1/2 year community college based program, a 4 year basic baccalaureate program, and a post-diploma entry program leading to a baccalaureate degree (these programs vary in length from 2 to 4 years).

McClosky (1981) conducted an extensive literature review on the effectiveness of nursing education as it related to competency, performance and quality of care. The author found that there was a lack of vigorous research in this area in that:

> (a) most studies compared the baccalaureate degree nurse with the associate degree nurse, few compared the baccalaureate degree with several types of nurses;
> (b) many students depended on perceptions of an educational group's performance rather than an individual's performance;
> (c) few good testing instruments were available; those produced by the quality of care movement have not proved useful in evaluating the effects of nursing education.
> (d) several studies were published only in Dissertation Abstracts and their existence and findings are not widely known.
> (e) few studies have included or controlled for the multiple job-setting variables and individual differences that affect job performance; more studies with a multivariate approach are needed. (p. 371)

In the review of the literature McClosky (1981) found that:

> . . . the baccalaureate nurse had more leadership and supervisory skills (Jacobs, 1980; Meleis & Farrell, 1974; Moore, 1967), was more care-oriented (Bullough & Sparks, 1975), more accountable (McQuaid & Kane, 1979; Moore, 1967), had more knowledge (Davis, 1972, 1974; Mandrillo, 1970); anticipated long-term needs (Gray et al., 1977; Jacobs, 1980), did planning and teaching (Jacobs, 1980; Schwirian, 1977, 1978, 1979) and considered the patient's psychosocial needs (Waters et al., 1972). . . . The diploma nurse scored higher on the State Board examinations (McQuaid & Kane, 1979; Zarett, 1980), performed more functions in practice (Davis, 1973), took physiological and cure-oriented actions (Bullough & Sparks, 1975; Waters et al., 1972) and had more self-confidence (Nelson, 1978). (pp. 370-371)

McCloskey also found that competency may not be indicative of good performance (McClosky, 1980, p. 371).

Schoen (1983) studied predictors of clinical competency of associate degree nurses. The study population was 73 members of a class graduating from a community college program. Supervisors rated graduates on five competency levels: (a) position competency, (b) work achievement, (c) communication skills, (d) cooperation, and (e) work success factors (p. 104). The four principal predictor values were: grade point average, final year clinical evaluations by program instructors, scores on the State Board Test Pool examination and the length of time it took the graduate to complete the program (p. 104). The time to complete the program was found to be one of the strongest predictors (p. 104). Schoen also studied numerous other variables and found:

> . . . the graduate's marital status at entry into the program had some value as a predictor, but age, prior education, employment while attending the program, previous health related work, and dependents did not. (p. 104)

McMillan (1985) compared professional performance examinations of graduate associate and baccalaureate degree nursing students on four dimensions: leadership, collaboration, research, and management of client care. The subjects were 83 students graduating from 12 associate degree nursing programs and 83 subjects from 11 bachelor degree programs. There were no differences noted between the two groups on leadership, collaboration or management of client scores, however, baccalaureate nurses scored higher on research scores. This author concluded that "either the test was not sensitive to detect all differences between the two groups, or the associate and bachelor degree subjects were not as different as generally supposed" (p. 167).

Field, Gallman, Nicholson and Dreher (1984) conducted an extensive literature review on three domains: cognitive, affective and psychomotor skills which were used to identify clinical competencies. Sixty-four of 490 NLN accredited baccalaureate programs provided information relative to the objectives used in their program. The findings revealed that a large number of clinical objectives were written at the cognitive domain. The study raises the question ". . . as to the abilities of students to be clinically proficient upon graduation when there are relatively few evaluation criteria written in the psychomotor domain" (p. 284).

Kieffer (1984) developed a rating scale of technical clinical skills that could be utilized by nursing educators "to teach for competency within the basic nursing program" (p. 198). The study was based on del Bueno's proposal that the clinical skills taught to students should be those which are most frequently performed and are considered most important in the community where they are employed (p. 198).

Competency of nurse practitioners. Ignatavicius and Naumann (1984) examined technical competencies of associate degree nurses, diploma and baccalaureate degree nurses in administering oral medications to patients. Six variables were "investigated as possible predictors . . . basic nursing education, drug knowledge, age, previous nursing experience, and highest nursing education completed" (p. 332). Sixty nurses (16 ADN's, 27 Diploma, and 17 BScN's) participated in the study and were observed twice as they administered medications. The authors concluded that the selected variables were not significant predictors of the technical competence of registered nurses (p. 332).

Bolton (1984) "proposes a conceptual framework based on the works of the learning theorist Paul Fitts" to assist educators and new graduates in obtaining the required clinical practical skills. Bolton concludes:

> . . . an examination of learning theory provides some answers to the many questions surrounding the psychomotor skill component of nursing education. But much work remains to be done. Researchers need to turn their attention to skills analyses and examine the "how" of teaching nursing skills. Is controlled simulation as a teaching/learning strategy an effective method for teaching complex nursing skills? What human rights issues are involved in using the clinical laboratory? How can we best use educational technology? How do environmental factors affect the capacity of the learner to acquire and perform specific skills? How do the motor elements of one task transfer to the acquisition of another, similar task? How can the costs of skill training--time and money--be minimized? How can the learning laboratory enhance the educational potential of clinical laboratory practice? Such research could provide the answers necessary to ensure that . . . students will possess both the academic and scholarly skills and the necessary clinical decision-making skills that will enable them to practice nursing confidently and comfortably. (p. 389)

Haughey, Stanton and Malizia (1985) in their article titled, "Essential Skills for Grads," conducted a study to determine whether there are differences in perceptions of administrators and educators in essential psychomotor skills for new graduates (p. 19). The study was conducted in eight counties in western New York. The major finding of this study was that "perceptions of essential skills for new graduates do vary among 2-, 3-, and 4-year faculty and administrators of hospitals, nursing homes and proprietary agencies" (p. 21). It is suggested that administrators and educators be studied separately since "differences in expectations have the potential for creating conflict" (p. 22). A further study was conducted by Stanton and Haughey (1986) and similar results and conclusions were drawn.

Del Bueno, Barker and Christmyer (1980) discuss the implementation of a competency-based orientation program for nurses at a 375-bed acute hospital located in Baltimore. The findings of this study suggest that a competency-based orientation program for staff reduces instruction time and learner time.

Ghiglieri, Woods and Moyer (1983) discuss the development, implementation, monitoring and revision of a competency-based project at Portland Adventist Medical Center. Various competency statements, including criteria, learning options and evaluation tool were developed by unit personnel and clinical instructors for various procedures carried out by nurses. The authors offer the following insightful comments about the project:

> . . . competencies have assured nursing administrators that each nurse who successfully completes a particular competency has demonstrated the potential of being a safe practitioner in that area. They also serve as excellent learning tools during initial orientation to our hospital or at the time of transfer to another department. An unexpected benefit of the competency project has been discovering obvious omissions of written policies, procedures, and system explanations. Competencies also provide an avenue for linking the nurse with policies, procedures, and other available resource material. Lastly, competency development has boosted the morale among staff nurses whose expertise has been recognized and utilized in determining competency standards. (p. 19)

Other nursing scholars have discussed the importance of continuing education as a means of maintaining competencies (Collins, 1981; Schoen, 1982). Sovie (1981a) stresses the need to "investigate before you educate." This author cites as an example the high number of medication errors being made by staff nurses. It was revealed during the course of investigation that the main problem was the delivery of patient care. Errors were being made because of a nurse's unfamiliarity with patients in a team nursing approach. Once a primary nursing concept was introduced errors decreased dramatically (p. 17). Sovie outlines steps to follow in identifying and classifying the problem.

Competency of nursing administrators. Keller and Bowen (1984) describe competencies required by first-line managers based upon del Bueno's model. The categories were divided as follows: functional management, employee relations, patient care, and leadership.

Fralic and O'Connor (1983) in their article titled, "A Management Progression System for Nurse Administrators: Part II," describe the skills and competencies required by chief executive nursing officers, associate/assistant, and head nurses.

Competency of clinical nurse specialists. Fenton (1985) conducted an ethnographic study with 30 master's prepared nurses to identify competencies and skills that:

> . . . can be utilized by nurse administrators to justify the cost of the advanced practice role and its contributions to organizational goals, and to

> serve as criteria for job descriptions, performance evaluations, and predictors of employment success. (p. 31)

Brenner's (1984) model on domains of nursing practise was enhanced by Fenton to include a consulting role.

In summary, an overview of the literature on competency has been presented in order to determine the nature and scope of competency. Basically, competency was described as the ability to meet standards for a particular behaviour. The literature surveyed on this topic in regards to student nurses, nurse practitioners, nursing administrators and clinical nurse specialists is contradictory in nature and one may ponder whether advancements have been made. In 1973, Abdella concluded that reliable tests for measuring clinical competence were nonexistent. "Wooley (1977) reviewed 77 years of evaluation tests and came to the same conclusion as Abdellah" (McMillan, 1985, p. 168).

If there are no reliable or valid tests for measuring clinical competency, then how does one measure the other end of the spectrum--incompetency. It is apparent that this area is fertile ground for further research. The literature reviewed suggests that nursing educators and administrators should conjointly define and develop a "philosophy on what constitutes training competent nurses" (Blanchard, 1983a, p. 43). This basically means developing skills lists outlining the cognitive, affective and psychomotor domains required to practise in a competent manner.

Summary

In this chapter, background information related to professionalism and competency in nursing practise was presented. This was done in two stages. First, an overview of the components of a profession as it applied to nursing was examined in order to determine whether nursing is a profession. Specifically, the components addressed were: (1) a systematic body of knowledge; (2) professional authority, (3) community sanction, (4) a code of ethics; and (5) the professional culture. It was found that nurses are a semi-profession since they have not yet developed autonomy and a body of knowledge unique to nursing. Several scholars concluded that nursing could achieve the status of profession if nurses were prepared: (1) to provide a unified approach to the complex problems confronting the discipline; (2) to conduct research projects and publish their findings; and (3) to create awareness of their roles and responsibilities. Nurses as members of a semi-profession appear to be in a unique position when compared with the well recognized professions on the one hand and with the semi-skilled occupations on the other. Nurses may be subject to discipline procedures that characterize the semi-skilled occupations, namely, grievance arbitration and civil lawsuits, as well as the discipline procedures of the professions that include professional discipline as well as civil lawsuits. That is, nursing practise is governed by all three: civil lawsuits, grievance arbitration and professional discipline. Should criminal action be involved, as with any occupation, a nurse may also be subject to a criminal lawsuit.

The second area examined was competency in nursing practise which was presented in order to provide a framework for examination of incompetency. It was found that there were no valid or reliable tests for measuring competency, especially in the psychomotor domain. Scholars suggest that educators and administrators conjointly develop skills lists to assess competency in the cognitive, affective and psychomotor domain.

The following chapter addresses the methodology which was utilized in this study.

Chapter 3

METHODOLOGY

Introduction

The problem of this study was to define unacceptable nursing practise in public hospitals using examples of case law, arbitration cases, and professional discipline cases as they related to the suspension and termination of nurses in Canada. One of the major sub-problems of this study was to provide operational definitions of negligence, incompetence, unskilled practise and professional misconduct based upon findings from the above cited cases. The methodology most suitable to a study of this type is content analysis incorporating grounded theory.

Content analysis is ". . . any technique for making inferences by objectively and systematically identifying specified characteristics of messages" (Holsti, 1969, p. 14).

Content analysis has been used extensively in society to describe events or processes (Chadwick, Bahr & Albrecht, 1984, p. 241). Studies of this type may range from public attitudes to minority groups, military involvement, inflation, unemployment, and how the public views various television programs and commercials (Chadwick, Bahr & Albrecht, 1984, pp. 239-241).

The advantages cited for using content analysis include:

1. it is non-reactive in that it does not involve interviewing individuals or using questionnaires;

2. the process is relatively inexpensive;

3. it can be used when the investigator is prevented from surveying or observing the population under study (Chadwick, Bahr & Albrecht, 1984, pp. 243-244).

The most difficult problem faced by the researcher who uses content analysis is locating messages relevant to the topic under study (Chadwick, Bahr & Albrecht, 1984, p. 245). In addition, the material available for analysis may not be representative of all such material (Chadwick, Bahr & Albrecht, 1984, p. 245). Content analysis has been viewed as particularly useful in reconstructing events in the past where the investigator may be denied personal access but may be able to accumulate records, cases or communications (Chadwick, Bahr & Albrecht, 1984, p. 245).

Mouly (1963) states that "without content analysis . . . the adequate description of data is impossible" (p. 281). Since content analysis relies on the validity of documents, Best (1970) cautions investigators to ensure trustworthiness of the data:

> Not only is the authenticity of the document important, but the validity of its content is crucial. The burden of proof lies with the researcher. It is his obligation to establish trusthworthiness of all data that he draws from documentary sources. (p. 133)

In essence, the research was a qualitative study. Bogden and Biklen (1982) present five characteristics of qualitative research:

> 1. Qualitative research has the natural setting as the direct source of data and the researcher is the key instrument.
> 2. Qualitative research is descriptive. The qualitative research approach demands that the world be approached with the assumption that nothing is trivial, that everything has the potential of being a clue which might unlock a more comprehensive understanding of what is being studied.
> 3. Qualitative researchers are concerned with process rather than with outcomes or products.
> 4. Qualitative researchers tend to analyze their data inductively. They do not search out data or evidence to prove or disprove hypotheses they hold before entering the study; rather the abstractions are built as the particulars that have been gathered are grouped together. Theory developed this way emerges from the bottom up, from many disparate pieces of evidence that are interconnected--it is called grounded theory.
> 5. Meaning is of essential concern to the qualitative approach. (pp. 27-29)

The term grounded theory, referring to a systematic method of research whose main purpose is to generate theory, was coined by Glaser and Strauss in 1967. These authors contend that "it does not take a 'genius' to generate useful grounded theory" (p. 11). The "advantage it offers the nursing profession is that it allows nurses to capture the complexities of a problem and the richness of life which make up so much a part of their practice" (Corbin, 1986, p. 91).

Corbin (1986) states:

> Grounded theory is not a replacement for the more "quantitative" approaches to research. It does, however, offer an alternative or supplementary means

> for generating and exploring problems through the use of data which does not easily lend itself to quantification (e.g., interviews, written documents, and observations). (p. 92)

The basic characteristics of qualitative research utilizing content analysis and grounded theory serve as a framework for the study. Areas of major concern are: (1) sources of data, (2) analysis of data, (3) the conduct of the research, (4) reliability, and (5) validity.

Sources of Data

The major sources of data for the present study were as follows:

1. Case documents--published and unpublished;
2. Legal documents;
3. Interviews.

Case Documents

Documents concerning individual cases (published and unpublished) were obtained from a variety of sources. Basically three stages were involved: (1) collection of arbitration cases, (2) collection of legal cases, and (3) collection of professional discipline cases.

Stage 1: Collection of arbitration cases. A preliminary investigation was conducted during the period April-May, 1984 in order to ascertain whether the study was feasible in terms of obtaining access to the cases. Miss Glenna Rowsell, Director of Labour Relations with the

Canadian Nurses' Association allowed the investigator free access to all files related to suspensions and terminations from employment of nurses in Canada. A total of 107 cases were incorporated into the study. The *Canadian Labour Arbitration Casebook* (Simmons, 1982) was then surveyed focusing on the period 1973-1986 in an attempt to retrieve cases involving disciplinary action against nurses for the following reasons: incompetence, medication errors, insubordination, neglect of duty, professional misconduct, absence (general and illness), alcohol and drug related, and religious grounds. The investigator then contacted nursing unions across Canada and requested copies of cases which related to dismissal for "just cause" and professional issues. The cooperation received from nursing unions was overwhelming, thus several unpublished cases are reported in this study.

Stage 2: Collection of legal cases. The Health Division Section of the Faculty of Law Library at the University of Alberta provided an extensive summary of negligence suits involving nurses during the period from 1900 to 1987. Copies of the entire court cases were obtained. A number of cases were not filed in the courts, therefore other means were sought to obtain the files. If a case had received newspaper coverage, clippings were surveyed. In three cases, the professional association provided their copy of the court proceedings. If clarification was required, interviews were held with legal counsel and/or individuals in the professional association who attended the hearing.

Stage 3: Collection of information related to professional discipline. A letter was forwarded to the Executive Director of the professional association in each provincial jurisdiction requesting the following information (see Appendix B):

1. The number of investigations which relate to professional discipline during the period 1973-1986.

2. The type of cases which were referred to the disciplinary committee and the action taken for each year during the period 1973-1986.

3. A copy of the nursing practise act and by-laws.

A response was received from each professional association, with the exception of the Yukon. Each association offered complete support of the study. The collection of the statistical information required a great deal of time and effort on the part of most of the associations since this information is not compiled on a systematic basis except in Ontario and Quebec where discipline cases are reported on a yearly basis to the membership. Several provinces also forwarded individual cases to the investigator with the provision that anonymity would be assured. The investigator at the commencement of this study was of the understanding that the access to individual cases would be limited since these cases are held "in private" and highly confidential. The privilege of being given access to copies of these cases was a major highlight to conducting this study.

The Province of Quebec forwarded professional discipline cases in French and the faculty members at Faculté Saint-Jean, the University of Alberta provided translation services. Where clarification was needed, telephone calls were made to the professional association.

Anonymity of individual names was assured in all circumstances where the case was unreported. All files were stored in a locked office.

Legal Documents

Legislation governing professional practise and by-laws in each provincial jurisdiction were examined for relevant information in regard to discipline. The information of major concern related to specific procedures for (1) handling of complaints, (2) conducting the investigation, and (3) outlining the steps to be followed in the appeal process. Legislation concerning the grievance procedure was also examined in each province and recognition was given to the fact that in some hospitals, the parties who hear the grievances at various stages may change as a direct result of collective agreements being negotiated with specific organizations.

Legal cases, legal texts and the Canadian Constitution were examined for their relevance to the study.

Interviews

Interviews were conducted with selected staff members in the professional nursing associations, nursing unions, and with educators, lawyers, and nurses.

The investigator utilized open-ended questions in order that opinions, events, and insights could be gleaned. Several of the interviewees for various reasons requested that their names not be released and therefore a list of specific names is not provided. However, their opinions and insights were reflected in the development of a classification scheme and in various other aspects of this study.

Data Analysis

The data were analyzed using content analysis and grounded theory. Turner (1981) suggests that the use of grounded theory in analyzing data is:

> . . . likely to be of maximum use when it is dealing with qualitative data of the kind gathered from participant observation, from the observation of face-to-face interaction, from semi-structured or unstructured ~~interviews,~~ from case study material or from certain kinds of documentary sources. (p. 227)

In this study, since the qualitative data primarily consisted of case studies, relevant document sources and interviews, grounded theory seemed to be the most appropriate method of analysis. The investigator adopted with minor modifications the nine stages suggested by Turner (1981) to develop grounded theory.

Stage 1: Developing Categories

Written materials, in the form of legal, arbitral and professional discipline cases, both published and unpublished, were analyzed in a consistent manner. The steps in the analysis process were as follows:

1. the relevant cases were identified and photocopied;
2. the cases were color coded as to type, i.e., legal, arbitral, and professional discipline;
3. the investigator reviewed each case paragraph by paragraph to identify key concepts and definitions;
4. each case was summarized with the following information included in the summary:
    a. date
    b. title of case
    c. type of case
    d. disciplinary action taken
    e. events leading up to the disciplinary action
    f. relevant information presented at the hearing, and
    g. judgement or award.

At this point, an initial classification format was developed for legal, arbitration and professional discipline cases.

Stage 2: Saturating the Categories

This term refers to the process of "accumulating data until the researcher feels confident that he or she is fully aware of what is meant when any new phenomena encountered are classified into the category in question" (Turner, 1981, p. 235). The investigator reviewed 107 cases paragraph by paragraph and concluded that any further categories would only "cloud the issue." The categories identified to 1987 appeared sufficient for the purposes of this study.

Stage 3: Abstracting Definitions

Turner (1981) considers this stage to be one of the most crucial to "the analysis, and often develops a deeper and more precise understanding of the nature of the phenomena being examined" (p. 236). The investigator in the process of abstracting definitions was able to reduce the categories even further. The categories which emerged for legal cases were:

1. Civil lawsuits
    - 1.1 Negligence
        - Patient related
        - Medication related
        - Procedure related
    - 1.2. Dismissal cases
2. Criminal lawsuits

Eight major categories were established for arbitration cases:

1. Incompetence (general and medication errors)
2. Insubordination
3. Neglect of duty
4. Professional misconduct
5. Absence (general and specific)
6. Use of alcohol or other drugs
7. Dismissal on religious grounds
8. Miscellaneous cases.

The professional discipline cases were categorized as follows:

1. Incompetence
2. Professional misconduct
3. Professional misconduct and incompetence
4. Alcohol related
5. Drug related
6. Mental illness
7. Interpersonal problems
8. Miscellaneous cases.

Stage 4: Using Definitions

Turner (1981) states, "that when a definition has been produced, it will both sensitize the researcher to recognize further instances of the phenomena in question and stimulate further thinking" (p. 236).

Glaser (1978) coined the term "drugless trip." Turner explains this as:

> . . . the stimulating and productive intellectual processes which occur when the process of writing in a fairly restricted way about definitions spills over into a more extensive and more discursive discussion of the data and of the patterns of ideas needed to order the material collected. (pp. 236-237)

Perhaps the most exhilarating experience encountered by the investigator was when categories began to emerge in more depth. For example, the definition of professional misconduct contains several concepts. A few concepts are provided as an illustration: failure to maintain the standard of the profession; patient abandonment; patient abuse; falsification of records; criminal charges; fraud; theft, misappropriating drugs or other property belonging to a patient or employer; and disclosure of confidential information.

Stage 5: Exploiting Categories Fully

At this stage, the investigator must be aware of categories that emerge as the research progresses. Turner (1981) suggests that:

> . . . if we feel that some of these categories are likely to be important for our investigations, the process of clarifying them and setting them out in this way will sensitize us to their possible existence, so that we are on the look out when they do occur. (p. 238)

Stage 6: Noting, Developing and Following-up Links between Categories

In this stage, causal relationships (tentatively hypothetical) begin to emerge. To cite one arbitration case example, a link between medication errors, negligence, incompetence, and professional misconduct became apparent. A nurse was accused of being "negligent" by an arbitrator even though the professional association discussed the complaint and felt the error occurred because of factors beyond the control of the nurse. This example suggests that the terms negligence, incompetence, and professional incompetence are being used out of context by both professionals and non-professionals.

Stage 7: Considering the Conditions under Which the Links Hold

When this stage occurs, the investigator questions why "one outcome occurs rather than another" (Turner, 1981, p. 239). It was interesting to note the discrepancies in the disciplinary action in the category of medication errors. In some cases, the dismissal was upheld when a nurse gave a patient the wrong drug. In other cases, nurses were reinstated or given payment in lieu of reinstatement. The investigator questioned the reasons underlying the decisions in the majority of cases presented in this study.

Stage 8: Making Connections, Where Relevant, to Existing Theory

The investigator attempted to link the emerging categories to several industrial relations and labour relations models (Anderson & Gunderson, 1982; Craig, 1983; Dunlop, 1958) and met with limited success. The theories and models failed to take into consideration legal, employee and professional responsibilities which are unique to professionals in an industrial relations setting. In the arbitration cases reviewed, there were clear distinctions as to what is expected of professionals and non-professionals and the types of penalties that were imposed, yet this is clearly not taken into account in the models. This area might prove fertile for further research.

Stage 9: Using Extreme Comparisons to the Maximum to Test Emerging Relationships

Glaser and Strauss (1967) discuss utilizing a "constant comparative method" which essentially means soliciting feedback from other scholars in various fields in order to ascertain whether the categories and concepts are relevant. The categories and definitions were reviewed by a labour arbitrator, a lawyer specializing in cases involving nurses, a nurse educator, a nurse administrator, and a nurse practitioner.

The analysis of the data resulted in the development of a classification schema as shown in Figure 3.1. The

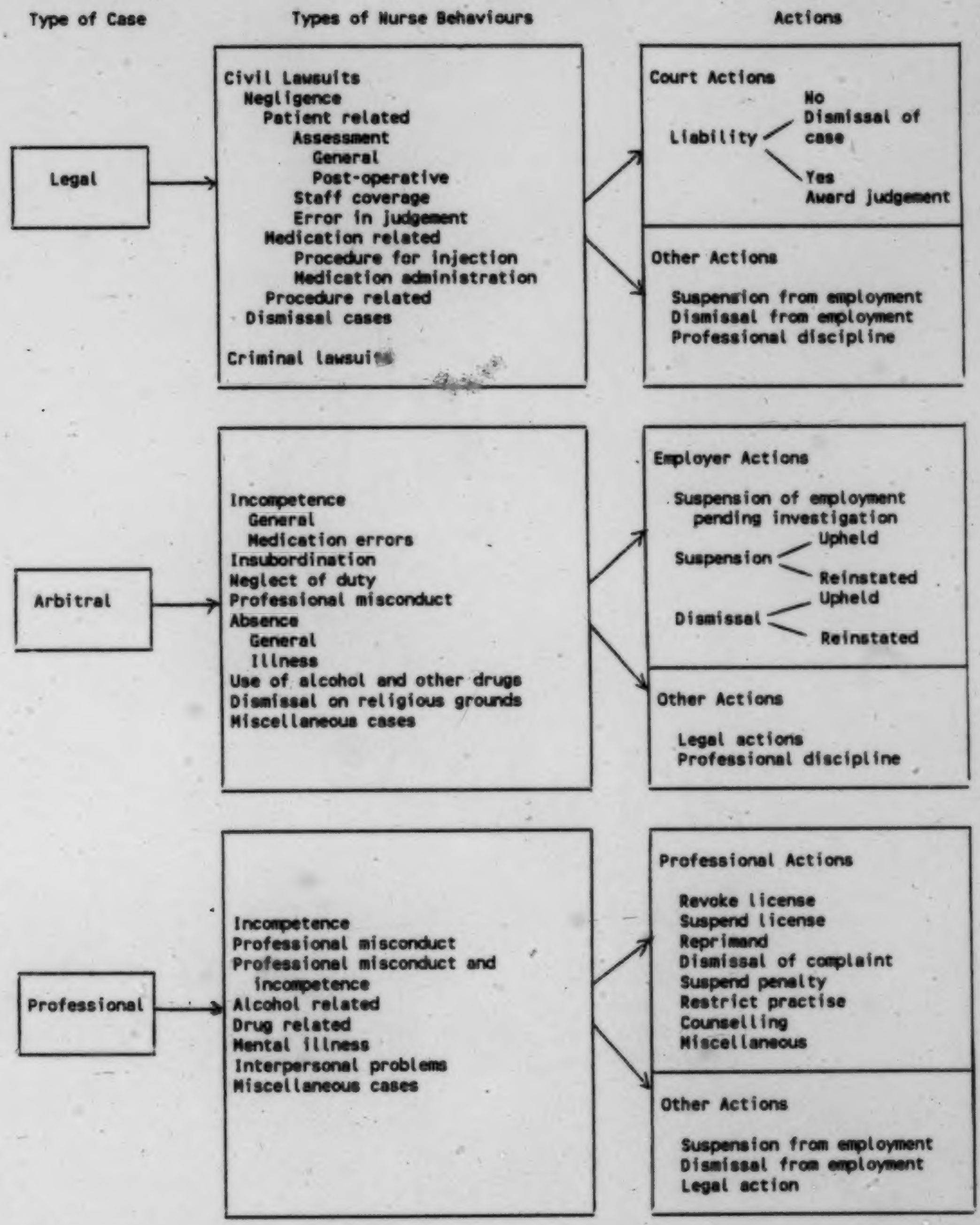
Type of Case
Types of Nurse Behaviours
Actions
Legal
Civil Lawsuits
Negligence
Patient related
Assessment
General
Post-operative
Staff coverage
Error in judgement
Medication related
Procedure for injection
Medication administration
Procedure related
Dismissal cases
Criminal lawsuits
Court Actions
Liability
No
Dismissal of case
Yes
Award judgement
Other Actions
Suspension from employment
Dismissal from employment
Professional discipline
Arbitral
Incompetence
General
Medication errors
Insubordination
Neglect of duty
Professional misconduct
Absence
General
Illness
Use of alcohol and other drugs
Dismissal on religious grounds
Miscellaneous cases
Employer Actions
Suspension of employment pending investigation
Suspension
Upheld
Reinstated
Dismissal
Upheld
Reinstated
Other Actions
Legal actions
Professional discipline
Professional
Incompetence
Professional misconduct
Professional misconduct and incompetence
Alcohol related
Drug related
Mental illness
Interpersonal problems
Miscellaneous cases
Professional Actions
Revoke license
Suspend license
Reprimand
Dismissal of complaint
Suspend penalty
Restrict practise
Counselling
Miscellaneous
Other Actions
Suspension from employment
Dismissal from employment
Legal action

Figure 3.1

A Schematic Presentation used in Classifying Unacceptable Nurse Behaviours Identified in Legal, Arbitral and Professional Discipline Cases classification scheme as presented serves as the framework for analysis of cases in Chapters 4 to 6. Three major areas are depicted:

1. type of case: legal, arbitral, and professional;
2. classification scheme for unacceptable nurse behaviours for each type of case; and
3. the actions which may occur as a result of the behaviour.

As an illustration, the area under investigation in Chapter 4 is legal cases. The cases were first divided into three major types, civil, disciplinary and criminal. The civil cases were further divided into negligence lawsuits with three sub-categories, patient related, medication related and procedure related.

The types of action which may occur as a result of the behaviour include:

1. dismissal of the case;
2. trial;
3. suspension from employment pending trial;
4. dismissal from employment pending trial;
5. discipline by the professional association which, depending upon the circumstances, could result in dismissal of complaint, counselling, re-training, reprimand, suspension of license or revocation of license.

Methodological Rigor

The question every researcher faces in the social sciences, regardless of whether the inquiry is regarded as scientific or naturalistic, is how to ensure that the findings of the study are a true representation of reality. As stated succinctly by Lincoln and Guba (1985):

> How can an inquirer persuade his or her audience (including self) that the findings of an inquiry are worth paying attention to, worth taking account of? What arguments can be mounted, what criteria invoked, what questions asked, that would be pervasive on this area? (p. 290)

Lincoln and Guba (1985) developed a framework for assessing validity and reliability in the context of a naturalistic inquiry. The terms and analogies are as follows:

1. Credibility (internal validity) refers to whether the inquirer's findings are a factual representation of the data sources.

2. Transferability (external validity) refers to the generalization of findings to other populations, settings and times. Lincoln and Guba (1985) suggest that researchers present a "thick description" of the research and data in order to facilitate judgement about whether transferability is feasible.

3. Dependability (reliability) refers to stability of the data either through the use of multiple sources of data, referred to as the overlap method or triangulation, or through an audit procedure.

4. Confirmability refers to the objectivity of the data. Guba and Lincoln (1982) suggest the use of triangulation and practising reflexivity, "that is, attempting to uncover one's underlying epistemological assumptions, reasons for formulating the study in a particular way, and implicit assumptions, biases or prejudices about the context or problem" (p. 248).

In this study, the main sources of data were published and unpublished legal, arbitration and professional discipline cases and interviews. Because the investigator was unable to interview nurses involved in the cases directly, to assure that the information was credible, other means were used to attest to the credibility, reliability, dependability and confirmability of the study.

An "audit trail" was established early in the study in order that an external auditor could examine the cases presented and verify their accuracy. First, all documents were photocopied and to ensure confidentiality kept in a locked room. Second, the cases were summarized and colour-coded as to type of case and category. This information was then given to a nursing colleague who was requested to review the "raw" data and assess whether the summarized case which included events, pertinent information from the hearing and the judgement were a true representation of the facts. The colleague, a former nurse administrator, presently engaged in research and education attested to the fact that the information was accurately reported. The investigator also forwarded sections of the paper to experts in legal, arbitral and professional discipline matters for their comments. A labour lawyer currently employed by a nurses' union, a nurse educator who is currently a Professor Emeritus at an eastern university, and formerly was a president of a professional association, and a nurse practitioner who is currently chairman of the professional discipline committee carefully reviewed the contents of the paper that dealt with their particular expertise. These procedures were carried out to assure credibility, dependability, and confirmability of the data.

A triangulation process was also used to assure credibility, dependability and confirmability of the data. The investigator was only able to interview three individuals whose cases are presented in this study to verify the congruency as to what was reported in the documents. In most instances where clarification was required, a staff member of the union or professional association was contacted to provide the necessary information or interpretation.

The investigator attempted constantly to examine the "reasons for formulating the study in a particular way, and implicit assumptions, biases, or prejudices about the context of the problem" (Guba & Lincoln, 1982, p. 248). The underlying reason for conducting a study of this magnitude was the investigator's genuine interest in the topic.

The investigator has experience in nursing as a staff nurse in a neonatal intensive care unit and community health setting, an employee relations officer, a nursing administrator and a nurse educator and therefore has witnessed the devastating effects of disciplinary action from a practising nurse, managerial and union point of view. Effort was continually made by the investigator to present an objective viewpoint.

Summary

In this chapter, the methodology was reviewed. The methodology of the study employed content analysis using grounded theory as a framework. Data sources included: case documents, published and unpublished, legal documents and interviews. In order to analyze the cases in a logical and systematic sequence, a classification scheme for unacceptable nursing behaviours identified in legal, arbitral and professional discipline cases was developed. To "attest" to the validity and reliability of the study, an audit trail was established in order that an external auditor could examine the cases and verify their accuracy.

In Chapters 4 through 6, legal, arbitral and professional discipline cases will be examined. Chapter 4 addresses the type of nurse behaviours which resulted in negligence lawsuits and the legal consequences of these behaviours.

Chapter 4

LEGAL CASES: LIABILITY IN NURSING PRACTICE

Introduction

The purpose of this chapter is to determine the types of nurse behaviours which resulted in negligence lawsuits and the legal consequences of these behaviours. The findings are reported in four sections. First, a general overview of the Canadian legal system is presented in order to familiarize the reader with the principles of common law and civil law as they relate to the practise of nursing in Canada. Second, the concept of "negligence" as it applies to nursing practise is discussed. Third, the literature in regards to nursing and law is reviewed with particular emphasis on standard of care, documentation, and failure to provide adequate coverage. This will be followed by a review of selected cases involving civil, disciplinary, criminal, and public inquiry proceedings.

Of prime concern to nurses is the fact that they are responsible and accountable for their actions. Guarriello (1982) outlines the current role of the registered nurse:

> The role of the registered nurse in the last two decades has changed from that of a passive, servile employee to that of an assertive, decisive health care provider. In 1982, the professional nurse monitors complex physiologic data, operates sophisticated life-saving equipment, and coordinates the delivery of a myriad of health care services.

> More importantly, today's nurse has the responsibility for exercising discriminating judgement and responding affirmatively. It is no longer the reasonably prudent nurse who waits for and blindly follows physicians' orders. Translated into the language of plaintiff's attorneys, this means that the standard of care for the registered nurse in 1982 bears little relationship to the standard of care for a registered nurse in 1962 or even 1975. Nurses can now be held liable for negligence more frequently, either jointly with other health care providers or independently. (p. 78)

During the Royal Commission Inquiry into the deaths of infants in the Neonatal Intensive Care Unit at Toronto Sick Children's Hospital, Gail Paech, President of the Registered Nurses Association of Ontario remarked that the inquiry:

> . . . has made nurses more aware of their roles and responsibilities in patient care. They have also learned more about the legal system and how to use it to protect themselves. . . . The hearings have united the profession and make it more aware of the importance of making its voice heard. (Charbonneau, 1985, p. 18)

Dr. Marion McGee, School of Nursing, University of Ottawa, added these insightful comments:

> . . . What's useful maybe is an increased attention to the reality of our accountability. We should derive from that an increased assertiveness, control and participation in decision making--not blind obedience. Nurses are the professionals in the final analysis, we have to be *responsible*. (Charbonneau, 1985, p. 18)

Nurses in the final analysis are accountable and responsible for their actions. It stands to reason that a strong knowledge base in legal responsibilities is required if nurses are to carry out their duties in a safe and competent manner.

The Canadian Legal System

The purpose of this section is to present an overview of the Canadian legal system in order to familiarize the reader with the concepts of common law and civil law as it relates to the practise of nurses in Canada. First, a definition of law is presented. Second, a general discussion on legal systems outlining the differences between common law and civil law practices ensues. Third, the sources of law are examined. This is followed by a discussion of the types of legal action. In this study, the cases examined are primarily negligence suits and these have been divided into three categories: patient related, medication related and procedure related. One civil case involving error in judgement is also discussed. Criminal cases are limited since the investigator could not access this information without the name of the individual. The trial of R. v. Nelles (1982) is highlighted in conjunction with the Royal Commission Inquiry into the deaths of children at Sick Children's Hospital.

Functions and Definition of Law

Gall (1983) states the law essentially serves two functions:

> First, it serves to order and regulate the affairs of all "persons" be they individuals, corporations or governments. Secondly, law acts as a standard of conduct and morality, variously directed at individuals and groups, businesses and governments.

> In short, through both of these functions, the law seeks to promote and achieve a broad range of social objectives. (p. 1)

James (1982) defines law as "a body of rules for the guidance of human conduct which are imposed upon and enforced among the members of a given state" (p. 5).

Gall (1983) states that it is important to:

> . . . realize that the legal process is part of an overall complex of interesting processes that form the lifeblood of modern, western, industrial society. . . . Legal, economic, political, socio-cultural and [professional] processes which design our society are highly interrelated and impinge on each other with assured regularity. (p. 4)

Legal Systems

The primary source of law is legislation enacted by the federal or provincial government. The Constitution Act (1982, s. 91-92) granted powers in regards to health and education to the provincial governments. This explains why the statutes in regards to nursing acts and health matters differ in each provincial jurisdiction. Picard (1978) states:

> Not all problems in society are governed by legislation, however, and in the absence of a statute, judges and lawyers refer to the case law, or the common law. This is a body of principles which have emerged from the written judgements of actual court cases, and is the chief component by which our legal system is distinguished from those employed elsewhere. (pp. 2-3)

Basically, two systems of law operate in Canada. The majority of provinces operate under principles of common law, the exception being Quebec which operates under principles of civil law. Gall (1983) presents an overview of the basic differences between these two systems:

> Fundamentally, the differences between the civil law system and the common law system relate not only to the importance of precedent in the common law system and the relative lack of precedent in the civil law system, but also to the general approach taken by the courts in the two systems. In a common law system, the courts extract existing principles of law from decisions of previous cases, while in the civil law system, the courts look to the civil code to determine a given principle and then they apply the facts of an instant case to that principle. If the code is silent in respect of a given matter, a judge will then attempt to apply general principles contained in the code to the specific fact situation before him. (Gall, 1983, p. 24)

In this study the majority of cases are civil suits which were judged on the basis of the doctrine of precedent and stare decisis. In other words, judges made decisions on a specific case based upon previous precedent setting cases.

Sources of Law

The two main sources of law are statutes and case law.

Statutes. "Statutes are the most important legal sources of law" (Gall, 1983, p. 31). The Constitution Act (1982) granted legislative authority to the federal parliament for certain matters (e.g., criminal law), while other matters are under the exclusive jurisdiction of the provincial legislatures (e.g., education, health).

Subordinate legislation (by-laws, ordinances, orders-in-council, rules and regulations) is legislation enacted by an individual, professional body or tribunal, whereby authority to do so has been granted by the legislative body.

The practise of nursing lies within provincial jurisdiction and therefore professional nursing acts, ordinances, by-laws, and definitions of incompetence and professional misconduct vary from province to province. It should be noted that federal statutes may impinge upon the practise of nursing, e.g., the process of distributing narcotics is regulated by federal statutes.

Cases. Judges often set out in writing:

> . . . the legally significant facts of the dispute, the rules of law which are brought into operations by those facts, and the reasoning used to reach a final decision in the case. The combination of these three elements is referred to generally as the reasons for decisions, or ratio decidendi of the case. (Picard, 1978, p. 3)

In common law, the decision of a judge may serve as a precedent when cases of a similar nature are heard. According to the doctrine of stare decisis, a judge of a particular court must follow the decision of the highest court within the particular jurisiction in which he resides (Gall, 1983, p. 220). In civil law, operating in the province of Quebec, a judge need not abide by precedent but as stated by Gall, (1983), "may rely on his own interpretation of a provision in the Quebec Civil Code" (p. 33).

Picard (1978) addresses the principle of stare decisis in the hierarchy of the Canadian courts:

> Decisions given in the Supreme Court of Canada are binding on all courts in Canada [note: in some cases a decision of the Supreme Court of Canada on a case originating in Quebec may not be binding in a common law province], and within each province the court of appeal binds all lower courts within the province. Decisions from provinces other than that of the court rendering a decision are not binding on that court but nevertheless would be considerable. High level decisions from other jurisdictions, for example, the House of Lords in England or the upper courts in Australia or New Zealand are not binding on any court but are extremely persuasive authority. . . . Decisions from American courts are rarely cited for authority in Canada. (Picard, 1978, p. 4)

Types of Legal Action

There are basically three types of legal actions which could involve nurses: civil action, disciplinary action and criminal action.

1. **Civil Action.** The Canadian approach to civil (and criminal) trials is adversarial:

> . . . the court attempts to arrive at the truth in a dispute by permitting each of the parties to the dispute to place his evidence before the court and to attempt, within the limits of the rules, to refute the evidence of the opposing party in the hope of ultimately defeating the opponent's case through proof and argument. (Philpott, 1985, p. 16)

Picard (1978) describes the civil procedure rules in her book titled, "Legal Liability of Doctors and Hospitals in Canada." The steps are as follows:

1. the complaint;
2. pre-trial procedures;
3. the trial; and

4. appeal.

Philpott (1985) summarizes the process:

> . . . a civil dispute takes place between parties known (usually) as the plaintiff and the defendant, (and depending upon the situation third parties may be joined). For example, if the hospital corporation is being sued in negligence, and the investigation shows that any liability of the defendant would be due to the negligence of a nurse employee the latter may be joined as a third party by application of the defendant . . .. The civil burden is on a balance of probabilities so that the plaintiff has to bring a little more evidence to bear than his opponent. If the plaintiff is successful damages (money to compensate for the loss) will be awarded or such other remedy as the court deems appropriate. (Philpott, 1985, p. 16)

2. **Disciplinary action.** A disciplinary action may be commenced against the nurse by the professional association for a breach against the standards of practise or code of ethics of the association. The case is heard by various committees of the association. The cases involved range from incompetence, drug or alcohol related problems, professional misconduct, neglect of duty, etc. The penalties range from a reprimand with certain conditions being applied (e.g., counselling, educational courses) to suspension, fines and revocation of license. The "action is designed to enable the association to maintain consistent levels of competence" (Picard, 1978, p. 7). Each provincial jurisdiction has developed a disciplinary process (which is detailed in the specific nursing acts and by-laws) in order to ensure that a fair hearing will be given. In the event that the nurse feels that the committee has made an unfair decision, an appeal

may be made to the association or the courts.

3. **Criminal action.** A criminal action is commenced by the Crown against those who violate acts which cause injury to the public. The criminal law of Canada, enacted by the federal government, is set out and defined in the Criminal Code (1970). The Criminal Code contains specific sections which are of interest to medical personnel: "manslaughter, infanticide, criminal negligence, criminal assault and theft" (Philpott, 1985, p. 16). It is imperative to note that

> The nurse who assists the physician or surgeon who is guilty of a criminal offense is deemed a party to the offense and punishable on account of it, notwithstanding the fact that she was acting pursuant to her superior's instructions. (Payne. 1967, p. 165).

In this section, an overview of the Canadian legal system was presented in order to familiarize the reader with the principles of common and civil law as they relate to the practise of nursing. It was found that two legal systems operate in Canada. The majority of provinces operate on the principles of common law and thus judges base their decisions on precedent setting cases. The province of Quebec operates on the principles of civil law and a judge must rely on the provisions outlined in the Quebec Civil Code.

The legal actions which involve nurses are civil and criminal lawsuits.

Negligence

The purpose of this section is to outline the concept of negligence. First, a definition of negligence, established in the English courts in 1856 is presented. Second, the four elements required to establish a case of negligence are reviewed. Third, the concept of direct and vicarious liability is examined with specific reference to the practise of nursing.

Definition

In 1856, the English courts defined negligence as the:

> . . . omission to do something which a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable man would not do. (Blythe v. Birmingham, 1856, p. 784)

Rozovsky (1974) outlines four elements required to establish a case of negligence:

1. Duty of Care: There must have been a legal duty on the part of the person being sued towards the plaintiff (the person suing) to exercise care . . . .
2. Breach of Duty: There must have been failure on the part of the hospital or the doctor to meet the standard of care and proficiency required by law.
3. Injury: The patient must have suffered some loss or injury. Carelessness not resulting in loss or injury does not provide a ground for action. This is the exact opposite to an assault suit in which it is not necessary to prove injury.
4. Causation: The plaintiff's injury must have arisen directly from the negligence of the defendant. In medical cases the question is usually whether the injury suffered is as a

> result of the negligence complained of or of the patient's original condition. (p. 47)

Philpott (1985) presents an excellent overview of the critical elements constituting actionable negligence for the field of nursing (see pp. 26-42).

Direct and Vicarious Liability in Negligence

Direct liability. A large majority of hospitals in Canada are incorporated under federal or provincial law. Philpott (1985) outlines the duties owed by the corporation directly to the patient:

> - a duty to select professional staff, using reasonable care;
> - a duty to review staff performance on a periodic basis;
> - a duty to provide reasonable supervision of staff;
> - a duty to provide for adequate staffing, equipment and resources, and appropriate work scheduling and organization. (p. 42)

The Board of Trustees of a hospital usually delegates the day-to-day management of affairs to the Executive Director of a hospital. In most instances, authority and responsibility for ensuring adequate staffing has been delegated to head nurses and/or charge nurses. In the legal case involving Krujelis v. Esdale, Fleming and Sisters of Charity of Providence (1972) a head nurse was found negligent in allowing three of the five nurses on duty to take a coffee break, thus leaving the recovery room unit inadequately staffed.

There are particular instances where hospital corporations are not responsible for the negligence of certain employees:

1. Physicians not employed by the hospital (Philpott, 1985, p. 43).

2. Private duty or special duty nurses who are employed and paid by the patient (Rozovsky, 1974, p. 19).

3. Independent contractors (Rozovsky, 1974, p. 22).

The status of volunteers, especially those involved with patients had not by 1974 been tested in the Canadian or United States courts (Rozovsky, 1974, pp. 23-24). The investigator was unable to locate cases related to the status of volunteers during the period 1974 to 1987.

Vicarious liability. Canadian law "recognizes a vicarious liability of employers for the negligence of their employees if and when the servant or employee was acting within the scope of his employment or authority at the time of the incident complained of" (Philpott, 1985, p. 44).

The hospital is vicariously liable for injuries suffered by patients as a result of negligence on the part of staff nurses (Fleming v. Sisters of St. Joseph, 1938). Rozovsky (1974) presents the argument that in certain situations, for example the operating room, a "nurse might cease being a servant of the hospital and become the servant of the surgeon or physician." This has been called the "Borrowed Servant" rule, and no cases in Canada or England exist whereby a hospital has been relieved of liability for a negligent nurse on the grounds of being a "Borrowed Servant" (Rozovsky, 1974, p. 19).

A nurse's duty is to execute the physician's orders in a safe and competent manner (Rozovsky, 1974, p. 19). If the nurse falls below the standard of care expected of her she will be negligent and the hospital will be held vicariously negligent. In the legal case involving Bustillo v. Misericordia Hospital (1983), a nurse, a pharmacist and a surgeon were held to be negligent when the incorrect medication was instilled into a patient's eyes during surgery. Each individual has a "duty" to carry out his skills in a competent manner.

A nurse may also be liable if "she carries out an order which as a professional she knows or ought to know was improper" (Picard, 1978, p. 272). In a recent landmark case in Alberta, a nurse was disciplined by the professional association and received a suspension when she followed the doctor's orders and gave an inordinately high dosage of a drug, which she knew when given could result in serious consequences to the infant.

The hospital is also vicariously liable for students. Rozovsky (1974) proposes the following safeguards:

1. All students should be under as strict supervision as possible with both supervisor and student being aware of each other's whereabouts and activities at all times.
2. While strict limits might assist in avoiding

> legal problems, this would obviously not be practical in situations where a student might be able to assist, but is forbidden to do so. Thus general guidelines as to student activities should be established, especially covering situations in which students are required to seek assistance or approval.
>
> 3. Students should be instructed not to undertake procedures in which they have not had training regardless of the circumstances, but should seek assistance.
> 4. Students should be instructed that if they are in doubt, they should seek assistance.
> 5. The nurse in charge of the unit in which a student is working should be able to place limits on the activities of individual students depending on their training, experience and performance.
> 6. Professional assistance should be immediately available . . . to students and not merely available by telephone.
> 7. To avoid conflicts between registered nurses and interns, a clear relationship and chain of command should be established in hospital rules. (p. 21)

In this section, a general overview of the Canadian legal system was presented with particular attention to functions of law, a definition of "law," legal systems, legal sources of law, types of legal actions, and negligence. One of the most significant facts expressed by legal scholars was that every individual who undertakes the care of another person must exercise a competent degree of skill and care. Rozovsky (1974) also cautions nurses and students that they should not perform a procedure or skill that they have not been previously trained to do.

An Overview of the Literature on Nursing and the Law: A Canadian Perspective

In this section the literature in regards to nursing and law will be reviewed with particular reference to the difference between negligence and malpractice and general considerations in negligence such as standard of care, documentation, and failure to provide adequate coverage.

Negligence Versus Malpractice

One of the first issues that has yet to be addressed is whether nurses are subject to negligence and malpractice. Picard (1978) offers insightful comments:

> . . . Negligence is the most common basis for a lawsuit against a doctor or hospital. Malpractice is a term that is often applied, sometimes even in statutes, to negligent practice but the scope of its meaning is not clear. Until the term is adequately defined by the legislature or the courts, its use is best avoided. (p. 49)

Morris (1982) states that negligence and malpractice are two separate torts and adds the proviso that "while any person may be negligent, only a professional may be liable for malpractice" (p. 6). He further states:

> . . . negligence is said to be . . . the omission to do something which a reasonable man, guided by those considerations which ordinarily regulate human affairs, would do, or doing something which a prudent and reasonable man would not do. Malpractice on the other hand, is a word of limitation to a class of wrongs committed by particular persons. It is a term associated with any professional misconduct, unreasonable lack of skill or fidelity in professional or fiduciary duties, evil practice or illegal or immoral conduct. (p. 6)

The Webster's Collegiate Dictionary (1974) defines malpractice as:

> . . . a dereliction from professional duty or a failure to exercise an accepted degree of professional skills or learning by one rendering professional services which results in injury, loss, or damage, . . . an injurious, negligent or improper practice. (p. 696)

Morris (1982) concurs with Picard (1978) in respect of the fact that the courts have not been consistent or technically correct in the use of these terms. In his words, "some have erroneously used the terms interchangeably" (Morris, 1982, p. 6).

In the Canadian lawsuits reviewed to 1987 by the investigator, the term negligence has been used by the courts and the hospital has been liable for damages which have ensued. If nursing achieves its professional status, nurses may be subject to malpractice suits. Since a legislative ruling regarding the term "malpractice" as it applies to nurses has not been made in Canada in this context, "its use is best avoided" (Picard, 1978, p. 49).

General Considerations in Negligence

The purpose of this section is to examine general considerations in regards to negligence. Three major areas are outlined and examined in the context of nursing practise: standard of care, documentation, and failure to provide adequate coverage where appropriate. Specific case examples are included.

Standard of care. Morris (1982) states:

> . . . a nurse owes to the patient not only the duty to possess that degree of learning and skill ordinarily possessed by nurses in good standing, but also to exercise that degree of care ordinarily exercised by other members of the profession acting under similar circumstances. (p. 7)

Sklar (1979b) in her article titled, "Error of judgement: Is it always negligence," discusses the importance of a nurse continually updating skills and knowledge:

> . . . the nurse is expected to deliver care based on her utilization of the knowledge and skills of her profession. This means that as the profession's body of knowledge expands and develops, the nurse must keep abreast of generally accepted professional knowledge, principles and practice. . . . Application of the principles of the body of knowledge further involves an assessment of the alternatives available and the consequences attendant upon them. Specific nursing care may be given automatically in response to a specific set of symptoms. The underlying process involves the nurse's recognition that a certain set of symptoms requires a specific nursing action. The nurse should know of the alternative courses of action available and their attendant consequences after she has learned that there is a specific professionally acceptance response to this set of symptoms. If she acts incorrectly, or fails to act, either because she fails to recognize the patient's difficulty or because she does not know what to do when faced with the symptoms, then her nursing decision and action/inaction would be the result of faulty exercise of judgement based on lack of knowledge. Because this conduct would fall below the standard of care of a reasonably prudent nurse, the faulty judgement here would amount to negligence and liability would attach. (pp. 14-15)

Several authors have addressed the standard of care in various situations: emergency department (Greenlaw, 1984), school nursing (Cohn, 1984), recovery room nursing (Rodgers-Magnet, no date), occupational health (Bowyer, 1983), caring for patient's belongings (Sklar, 1979f), infection control (Sklar, 1979c), confidentiality (Sklar, 1978c), use of siderails (Greenlaw, 1982b), and informed consent (Sklar, 1978a). Caution should be exercised when reviewing these articles since several pertain to the United States.

Documentation. The medical record is:

> . . . a source of information which serves as a basis for the patient's care and treatment . . . it must be sufficiently detailed, accurate, and readily available to those who depend upon it. It must state precise terms of treatment and reactions to treatment, where various events affecting the patient took place, and the names of those who were in attendance at the time. In other words, the patient's record must provide as complete a picture as possible of what happened to the patient from admission to discharge. (Rozovsky, 1974, pp. 64-65)

Sklar (1978b) in her article titled, "The legal significance of charting," offers these precautions:

> - Pooling observations towards the end of shift, for example, or recording information for a colleague casts a shadow on the validity of the record.
> - Omitting routine events from charting can also be dangerous. What is routine for patient A may be, for patient B, a symptom necessitating medical or nursing action.
> - Erasures can also create doubts about the validity and credibility of recordings. When you make a mistake on a chart, you should draw a line through the error, make a written indication of "error," initial it and make the correct entry immediately after. (p. 11)

The importance of charting accurately cannot be overemphasized. Nurses often assert that the amount of paperwork required of them is horrendous. With the introduction of flow sheets and computer technology in some intensive care units, nurses are often "triple charting." A staff nurse in a neonatal intensive care unit cited her frustration with the introduction of new systems designed to make charting more efficient:

> First, we chart on this new flow sheet, then we chart on the nursing care record, and then we are supposed to punch into the computer the treatment and medications given. What is so frustrating is that by the time we care for the infant and put the information into the computer, the computer tells us we have committed a medication error because there is a time lapse of one hour between the time the medication should have been given and was given, and the time when we finally punched into the computer. (Personal communication, August 10, 1987)

The implementation of new charting systems can be frustrating and time-consuming to practitioners but may prove to be worthwhile in the long run. The Hermann Hospital in Houston, Texas recently conducted an evaluation on a "flow sheet" documentation system and found:

> 1. significant cost savings in nurse charting time per patient;
> 2. creation of a simple check list for nurse documentation for equipment and supplies;
> 3. improved quality assurance scores;
> 4. increased nurse/MD satisfaction with documentation; and
> 5. development of a standard approach to quality charting. (Weeks, 1985, p. 22)

The flow-sheet system of documentation is designed so that times can be recorded as soon as the procedure/treatment or medication is given. In a recent legal case, Joseph Brant Memorial Hospital and Malette v. Kozial et al. and Jeffries (1977), the judge stated:

> . . . the failure of the nurse to chart between 2000 hours and 0500 is a definite breach of record keeping. On a ward with a great many patients, the medical record becomes the source and direction for patient care. If kept properly, it indicates on a regular basis the changes in the patients' condition and alerts staff to developing dangers . . . if the hospital enforced regular entries during each nursing shift, a nurse could not make the entry until she had first performed the services required of her. . . . The absence of entries permits the inference that nothing was charted because nothing was done.

Nurses in this particular case were held to be negligent because they failed to: (1) carry out the proper care and (2) document the care that was provided. Thorton (1986) summarizes the importance of charting:

> . . . to avoid legal trouble, you must know how to chart defensively--as well as accurately. When you record an entry on a chart, imagine that a lawyer is peering over your shoulder. If you look at the entry through his eyes, you'll chart more safely. (p. 57)

Failure to provide adequate coverage. This topic deserves particular attention because of the problems that have ensued not only in the legal entity but also in a particular arbitration case. Some nurses and unions have argued that during an unpaid coffee break or meal break a nurse is entitled to do as she wishes and this means sleeping, or going out of the hospital for breaks. Extreme caution must be exercised since it is the nurse's responsibility to ensure that

> . . . in one's absence, patient safety and well-being are properly safeguarded . . . failure to do so may amount to a breach of duty and may result in a finding of negligence and liability where harm befalls a patient. (Sklar, 1979a, p. 17)

The following cases illustrate the necessity of ensuring that the unit has proper coverage before taking a coffee or meal break.

In the legal case involving Laidlaw v. Lions' Gate Hospital (1969), a patient suffered severe brain damage as a result of respiratory arrest in the recovery room. At the time of the incident, only one nurse was working in the recovery room and attending four to five patients while the other nurse was on coffee break. The nurses were held to be negligent in that one nurse failed to observe the patient every three to four minutes, and the other nurse was found to be negligent in taking a break when she knew that other patients were expected from the operating room. The nurse should have arranged coverage from the nursing supervisor and waited until help arrived before leaving on a coffee break.

In the legal case involving Krujelis v. Esdale, Fleming and Sisters of Charity of Providence (1972), a five year old boy suffered respiratory distress followed by cardiac arrest in the post-anaesthesia recovery room. The patient had just undergone plastic surgery to correct an ear deformity. Because the symptoms of the arrest were not detected, the patient suffered irreversible brain damage and did not regain consciousness. At trial, some three and one half years later, it was expected that the patient would not live for another year--the patient died two months later. At the time of the incident, three of the five nurses assigned to the unit were on coffee break. The patient had not been observed for a period of at least twenty minutes.

The nurses were found to be negligent in that they failed to provide the patient with adequate observation:

1. Three nurses failed to return from coffee break in time to check the patient's condition. The nurses were also absent from the unit thus leaving the recovery room inadequately staffed.

2. The head nurse was negligent in that she allowed three nurses to be absent at the same time.

3. The head nurse and the one remaining nurse were negligent in that they failed to: (a) check the condition of the patient with frequency or care, (b) observe visually what was happening to the patient, and (c) position the patient in a place where he could be observed.

In this section, general considerations regarding standard of care, documentation and failure to provide adequate coverage during breaks were reviewed in order that background information could be presented to the reader.

The major purpose of this chapter is to determine the types of nurse behaviours which resulted in negligence lawsuits and the legal consequences of these behaviours. The following section of this study will be divided as follows: civil lawsuits involving negligence, civil lawsuits involving dismissal from employment, and a criminal lawsuit involving alleged murder and a public inquiry into the death of children at Sick Children's Hospital in Toronto. In Figure 4.1 a schematic presentation for classifying unacceptable nurse behaviours is presented. The negligence lawsuits have been subdivided into the following areas: patient related, medication related, and procedure related. The actions which could result as a consequence of these behaviours include: dismissal of case, trial, suspension from employment, dismissal from employment, and discipline by the professional association.

A Review of Selected Legal Cases

Civil Lawsuits and Nurse Negligence

Civil cases involving nurses held to be negligent have occurred for a variety of reasons. During the period 1904-1928, the lawsuits which ensued were related to procedures, e.g., hot water bottles being placed in the patient's bed and causing burns. In the early 1940's trends appeared to change and nurses were involved in lawsuits related to medication administration. For example, in one case a nurse instilled the incorrect dosage of silver nitrate into a newborn's eyes. In later cases, nurses were found to be negligent in administering an injection of medication in close proximity to the

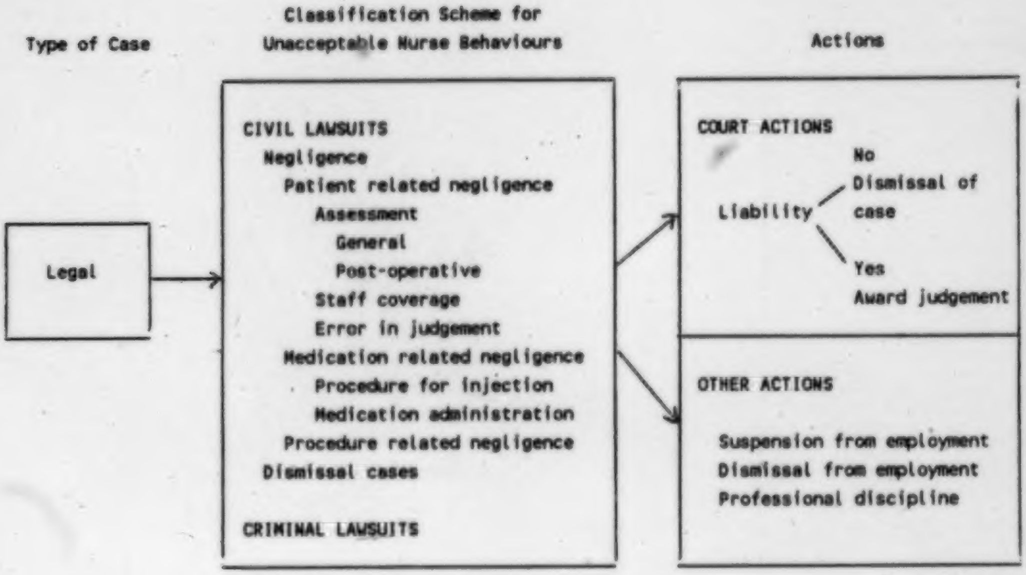
Type of Case
Classification Scheme for Unacceptable Nurse Behaviours
Actions
Legal
CIVIL LAWSUITS
Negligence
Patient related negligence
Assessment
General
Post-operative
Staff coverage
Error in judgement
Medication related negligence
Procedure for injection
Medication administration
Procedure related negligence
Dismissal cases
CRIMINAL LAWSUITS
COURT ACTIONS
Liability
No
Dismissal of case
Yes
Award judgement
OTHER ACTIONS
Suspension from employment
Dismissal from employment
Professional discipline

Figure 4.1

A Schematic Presentation for Classifying Unacceptable Nurse Behaviours Identified in Legal Cases sciatic nerve and causing "foot drop" or nerve damage as a result.

In the 70's and 80's a new trend appears to be emerging. Nurses are facing lawsuits for their assessment and observation skills, their documentation skills and for leaving the unit without ensuring proper staff coverage. The specific cases are now reviewed in the following section.

Patient related negligence. In the legal case involving Bergen v. Sturgeon General Hospital (1984) a 20 year old pregnant female was admitted to hospital and diagnosed as having pelvic inflammatory disease. Five days later she was transferred to another hospital and died 13 hours following surgery from septic shock as a result of a ruptured appendix. Two nurses were found to be negligent: (1) the charge nurse was found to be negligent when she accepted an assessment of a patient unfamiliar to her from another nurse unfamiliar with the case. She also did not inform the incoming charge nurse that the patient should be monitored closely; (2) the second nurse was negligent in that she took upon herself an assessment of a situation she had not seen before (ruptured appendix) and did not contact a physician.

The lesson to be derived from this case is that nurses owe patients a reasonable standard of care. It is a nurse's duty to assess a patient in a systematic manner and report any changes in condition to the attending physician. All information must be carefully documented as to time, event and when the physician was informed. Creighton (1986a) cautions nurses to listen to the requests of patients/families and/or significant others. She further states:

> . . . patients and families seldom sue nurses or their employers if they feel that the nurse has done her best to care for the patient. Being kind and concerned about patients' feelings as well as their physical condition is more than courtesy. Remembering that the patient is the family's loved one helps each of us understand and respond appropriately to their needs. (Creighton, 1986a, p. 15)

In the legal case involving Joseph Brant Memorial Hospital and Malette v. Kozial et al. (1977), a patient died following a spinal fusion as a result of aspirating gastric fluids. The judge stated that the nurses failed to provide the proper care and a correct assessment of the patient's condition. Expert witnesses at the trial testified that the patient should have been roused and encouraged to deep breathe and cough, fluid intake should have been monitored closely and vital signs should have been monitored at frequent intervals. The judge stated that

> merely looking at a patient is not sufficient--the nurses should have realized that post-operative patients are normally restless and if a patient is pale and sleeping this is in itself a danger signal. (p. 177)

The nurses were also held to be negligent for their failure to chart on the patient's condition between 2000 hours and 0500 hours. The judge surmised that ". . . the absence of entries permits the inference that nothing was charted because nothing was done" (p. 177).

In the legal case involving Downey v. Rothwell (1974) a nurse was found to be negligent since she failed to take precautions and place a patient in a position where she could not harm herself. The patient, an epileptic, sensed an "aura" and went into the doctor's office and asked the nurse for assistance. The nurse left the patient in the examination room unattended for approximately one minute. During this time the patient experienced a grand mal seizure, fell onto the floor and fractured her arm. The nurse was held negligent in that

> An epileptic, on the threshold of a seizure should be placed in a position of safety, preferably on the floor, and not left unattended; knowledge of such precautions was to be imputed to a trained professional nurse and a patient was entitled to expect a standard of care consistent with such knowledge. (p. 311)

In two specific instances, nurses were found to be negligent in failing to: (1) ensure that the unit was adequately staffed, and (2) observe the patient's condition with frequency or care (see Kruielis v. Esdale, Fleming and Sisters of Charity of Providence, 1972; and Laidlaw v. Lions' Gate Hospital, 1969). These cases were discussed previously in the chapter. The lesson to be learned in these cases is that nurses have a responsibility to ensure that a unit is adequately staffed prior to leaving. Nurses also should report on their patients' conditions to the nurse who will be relieving them prior to going for a coffee break or meal break.

In one particular legal case, Child v. Vancouver General Hospital (1970), a nurse was not held to be negligent because she had notified the physician that the patient was restless and confused. By the time that the physician arrived, the patient had settled and the physician was of the opinion that the patient's condition had improved. The nurse left for her coffee break and when she returned found that the patient had tried to escape out the window and fell on a canopy one floor below sustaining serious and permanent injuries. The nurse was not found negligent because in the words of the trial judge:

> . . . to suggest that the nurse was negligent when the opinion with which she acted coincided with that of a certified surgeon, who was in charge of the case is . . . to ask more than is required of a reasonably careful and capable nurse. (p. 478)

Medication related negligence. Several lawsuits have ensued because either the incorrect medication was given or the nurse injected the medication near the sciatic nerve causing damage to the nerve.

In the legal case involving Bustillo v. Misericordia Hospital (1983), a patient undergoing cataract surgery had an incorrect solution instilled into the eyes causing severe damage. The product that was supposed to be instilled was normal saline. During the course of the surgery, the surgeon requested to see the product being used, since he noticed an irregularity in the nature of the contents. After examining the product he still proceeded to use it. It was found that the hospital was liable for the negligence of the pharmacist in preparing the product and the attending operating room nurse. The trial judge in his concluding remarks stated:

> . . . the use of a new product in the treatment of a patient imposes upon a medical doctor an especially heavy burden vis-a-vis the standard of care to be applied. Hence, and although a hospital in which the treatment takes place may be found negligent by reason of its pharmacist's error in preparation of the product, and that of the attending nurse in presenting that product to the doctor, it is incumbent upon the doctor to 'see what is there to be seen.' When he looks at the product, but fails to observe that it is not the proper product, his negligence . . . must be found to have been a substantial cause of the injury.

In the legal case involving Barker v. Lockhart (1940), a head nurse instilled a solution of over 40% silver nitrate into the infant's eyes causing blindness in the left eye and severe damage to the right eye. The normal amount of solution to be administered was 1%. The nurse was found to be negligent in that she failed to administer the correct dosage of solution and should have taken care when using a bottle which had not been labelled.

A nurse is responsible for ensuring that in giving an intramuscular injection into the buttock that care must be taken in order to not cause damage to the sciatic nerve. This procedure is taught in schools of nursing and is a minimal competency. Several nurses have been found negligent for failure to perform this task in a skillful manner (Fiege v. Cornwall General Hospital, 1980; Huber v. Burnaby General Hospital, 1973; Laughlin v. Royal Columbia Hospital, 1971). Of special note is the fact that the nurse should have adequate lighting when an injection is given. In the legal case involving Huber v. Burnaby General Hospital (1973) a patient received damage to the sciatic nerve as a result of the injection being close to the sciatic nerve. The incident occurred during the night (0400 hours) when all the lights, except the nightlight, were off. The nurse stated she used a flashlight, but another patient in the room stated she saw no flashlight being used. The hospital was held liable for the negligence of the nurse.

In the legal case involving Bugden v. Harbour View Hospital (1947) two nurses were found negligent for failure to take proper care when administering a dangerous drug. In this case, the patient entered hospital for treatment of a dislocated thumb. The physician asked nurse A for novocaine, nurse A asked nurse B for novocaine and was given adrenaline. The patient died as a result of receiving an injection of adrenaline. The physician was not found negligent in failing to look at the bottle since he was entitled to rely on experienced nurses. The nurses were held to be negligent. Nurses have the responsibility to ensure that the right medication in the right amount is given to the right patient by the right route and at the right times. This is one of the first concepts nurses learn, however there is overwhelming evidence that errors occur in 10% of the medications given (cited in Midale Hospital v. Saskatchewan Union of Nurses, 1986). The importance of checking the patient's armband and to see that it is the right patient cannot be overstated. Some hospitals are now in the midst of returning to a primary nurse system whereby a nurse who cares for the patient is responsible for administering the medication as opposed to a system whereby one nurse is responsible for administering medications to all patients (team nursing). It is felt that this would decrease the number of errors which could occur.

Nurses were not found to be negligent in two legal lawsuits involving the administration of medications. In the legal case involving Buchanan v. Fort Churchill Hospital (1969), a patient fainted shortly after being given an injection of thorazine and as a result fell to the floor and sustained a broken cheek bone. The nurse was not found negligent in that it was impossible to foresee a fainting spell.

In the legal case involving Wilcox v. Cavan (1974), a nurse injected bicillin into the deltoid muscle, observing the normal practise of aspirating the syringe to see that no blood was present. The antibiotic entered the circumflex artery and the patient developed gangrene in part of his hand, necessitating amputation of several fingers. The nurse was not found to be negligent in that she was not aware of the potential danger involved in administering a drug in close proximity to the circumflex artery.

Procedure related negligence. In the lawsuits examined to date, the majority of injuries occurred to patients who received burns from hot water bottles (Armstrong v. Bruce, 1904; Bernier v. Sisters of Service St. John's Hospital, 1948; Eek v. High River Municipal Hospital, 1926; Nyberg v. Provost Municipal Hospital, 1927). The practise of placing hot water bottles in patient's beds following surgery, a procedure designed to combat shock, was a fairly common practise during the early 1900's to the 1950's. The procedure at present is to place warm blankets on a patient following surgery.

In the legal case involving Harkies v. Lord Dufferin Hospital (1931), a three year old child was severely scalded and it was judged that the injury was due to an absence of care on the part of the nurses. The child was receiving inhalation therapy as part of the treatment regime for pneumonia. The nurse was in an adjoining room and when she returned, it was discovered that the patient had been severely scalded.

In the legal case involving Farrell v. City of Regina (1949), a student nurse was weighing an infant, and during the procedure the infant rolled off the scale onto a hot radiator and received burns to his chest, abdomen and thighs. At trial, the judge stated that the nurse should have taken into consideration the activity level of the child and kept one hand on the infant at all times. The student nurse was found negligent in that she did not exercise a high degree of care for the protection of the infant.

In the legal case involving Fleming v. Sisters of St. Joseph (1938), a nurse was administering diathermy to a patient and set the electrical current at a higher rate causing severe burns to the patient. The hospital was held vicariously liable for the defendant nurse's negligence.

Situations involving procedures for protecting patients from harm in psychiatric settings have been contentious. During the early 50's, patients were discharged in large numbers from psychiatric facilities and integrated into the community. An "open door" policy was instituted in most psychiatric hospital settings and large psychiatric facilities with the exception of forensic and the acutely disturbed units. Special policies and procedures were developed for instances where a patient required seclusion or constant observation because of the possibility of harming others or causing harm to himself. Fatal inquiries and review of policies and procedures have occurred when a patient elopes from a hospital and injures himself or dies. In the legal case involving Worth v. Royal Jubilee Hospital (1980), the hospital, physician and nurse were not found negligent in that it was not reasonably foreseeable that the patient would attempt to elope from the hospital by means of a roof garden wall and thus injure herself. The situation in this particular case is as follows. A 23 year old, certified under the Mental Health Act, was being treated at the psychiatric hospital for depression, dependency on placidyl, and potential suicidal behaviours. The patient was very upset by the environment on the unit and also the possibility of being transferred to an acute psychiatric intensive care unit. The patient attempted to elope from the hospital via the hospital's roof garden, fell 30 feet, and suffered severe injuries resulting in paraplegia.

It is not known whether the nurses who were found negligent in the cases examined were dismissed from employment or whether an investigation was conducted by the professional association. In some situations it is known that nurses were requested to resign voluntarily from the hospital and complied. It is also known that in some situations nurses were voluntarily requested to resign from the hospital and complied (Personal communication, August 7, 1987). The facts of the matter are at best highly speculative, since these matters are not openly discussed.

Civil lawsuits and dismissal cases. The two cases described in the following section involve directors of nursing who were dismissed from employment. The situations are similar in nature. In nursing, head nurses (in some instances), directors of nursing, associate directors of nursing and vice-presidents of nursing are classified as out-of-scope. Basically, this means that they are not covered by a collective agreement and unlike nurses who are in-scope and can grieve their dismissal through an arbitration board, the only recourse to nurses out-of-scope who are dismissed is through the courts.

In the legal case involving Coventry v. Nipawin and District Nursing Home (1981), a director of nursing sued her employer for damages for wrongful dismissal. The employer pleaded just cause for dismissal. The issue before the courts was whether the employer had sufficient grounds for dismissing the nurse (p. 41). Prior to her dismissal in July 1977 the nurse had been employed at the hospital for a period of 12 years, first as a matron and then as a director of nursing. In July, the director of nursing requested that a provincial nursing consultant investigate the nursing home. The consultant conducted an investigation and reported deficiencies to the hospital board. Upon receipt of the consultant's report, the hospital board requested that the director resign and when the resignation was not tendered she was dismissed without severance pay. In the termination letter, the director of nursing was informed that she was being "relieved of her duties because she did not adhere to government regulations and failed to carry out duties prescribed by the hospital board." At trial, the judge stated:

> . . . the crux of this case was the failure of the defendant to afford to the plaintiff an opportunity to rectify the problems raised in the report. None of the consultant's concerns were of such a magnitude that the defendant should have assumed that the plaintiff could not correct them. Had the defendant wished to be reasonable in the circumstances it would have instructed the plaintiff to carry out the recommendations of the report or lose her job. Instead, the plaintiff was fired without being given a chance to make amends. It is noteworthy that at no time during her employment was the plaintiff warned that her position was in jeopardy. (p. 42)

The director of nursing received a judgement of $10,000 or approximately one year's salary.

In the legal case involving Charlesworth v. Morris Hospital District (1982), a director of nursing who had been employed by the hospital as a registered nurse for seven years and as a director of nursing for six years was dismissed by her employer without warning on August 2, 1979. In April 1979 a management survey was conducted. The director of nursing was interviewed by the survey team a total of one hour. The final report issued by the survey team

> . . . firmly recommends the release of [the administrator and the director of nursing] and expresses very critical comments about the administration of the hospital district, including the nursing department. (p. 339)

The charges against the director of nursing specifically centred around:

> . . . the apparent finding of lack of communication within . . . staff, with resulting tension 'manifesting itself in poor staff morale, a reduced standard of patient care, and strained relationships between the medical staff and nursing.' Related to this and the only other specific allegation was the finding of 'unfair employee treatment, discrimination, and inconsistent application of personnel policies.' (p. 341)

After hearing the evidence, the judge stated that the director of nursing is:

> . . . a dedicated, competent and able nurse, with a strong sense of the traditional professional character of that occupation. As Director of Nursing she showed a strong will and a dominant personality, and perhaps was not entirely democratic or perfectly even handed in all she did. Nevertheless I am well satisfied that her conduct in the exercise of her duties was perfectly appropriate for a person charged with . . . administrative responsibilities and who lacked instruction and assistance from above. There is simply no basis for the suggestion . . . to the effect her administrative performance was below acceptable standards. (p. 342)

The trial judge felt that because she did not gain employment for at least a year following the dismissal and because of the physical and mental trauma associated with the dismissal, the nurse was entitled to ten months' severance pay. Since three months' severance pay had already been paid, the employer was ordered to pay damages of $11,774.

The fact that only two cases of disciplinary action were heard before the courts is surprising. An extensive computer search was conducted by the Health Law Project, Law Centre, University of Alberta, for the period 1973-1986 and although several legal cases were found related to powers of arbitration boards, the terms of reference of a commissioner in a public inquiry, and specific cases involving nurses and unjust dismissal which were heard by an arbitration board, cases related to nurses and civil lawsuits for dismissal for unjust cause were limited in number.

A known fact in nursing is that several administrative nurses have been dismissed, one of the main reasons being political. Administrative nurses (out-of-scope) have been instructed to "clean out their desks in an hour," been escorted out the front door and even had the doors to their office locked with no prior warning or justification given for the dismissal. One nursing administrator stated:

> . . . if you're strong, believe in nursing and all it stands for, stick up for the patients and your staff, you can be assured that you will wear the battle scars. You may be one of the most competent individuals, highly respected in your profession but still go through the experience of being dismissed. It's like a growth experience--when you go through the trauma and the disruption it has on your life, you eventually come out a better person. (Personal communication with a nurse administrator and educator, April 10, 1987)

One may question why some nursing administrators have not taken legal action against their employer for unjust dismissal. There may be several reasons for this. First, some may have received substantial severance pay, and may just want to get on with their lives. Second, some may feel that if they take action it will have an effect on their future employment opportunities. These answers are only suggestive, however an in-depth study of management nurses who have been dismissed might be fertile ground for future research.

Rowsell suggests that management nurses who are out-of-scope should have a contract with their employer. Explicit in this contract should be the terms and conditions of work (e.g., hours, holidays, salary) and severance pay if dismissed (Personal communication, G. Rowsell, April 1984). Other scholars and administrators have suggested that head nurses who are out-of-scope should consider the formation of a separate union (Personal communication, Dean, School of Nursing, September 16, 1986). These are only a few of the possibilities open to management nurses. In the future, as head nurses are taken out-of-scope because of their involvement in hiring and dismissal, and the budgetary process, an increasing number of lawsuits may ensue.

Criminal lawsuit and a public inquiry. One of the most controversial cases that has had a major impact on all nurses in Canada centres on the events surrounding the deaths of children at Sick Children's Hospital in Toronto. During the period July 1, 1980 and March 31, 1981, 34 seriously ill infants died. An investigation revealed:

> . . . that it was likely some of the children did not die from natural causes in the sense that they did not die from the disease or illness for which they were hospitalized, rather it was suspected that some of them had died because of the administration of an excessive amount of the drug digoxin while they were on the cardiac ward. (Nelles et al. and Grange et al., 1984, p. 81)

Following the death of one infant on March 22, 1981, the Toronto Police Force conducted an investigation and Susan Nelles was arrested on March 25, 1981 and charged with the first degree murder of four of the children. It was:

> alleged against Miss Nelles that those children had died because lethal doses of the drug digoxin were administered by her when these children were patients on the cardiac ward. (Nelles et al. and Grange et al., 1984, p. 81)

On January 4, 1982 Justice D. Vanek commenced a preliminary inquiry in the Provincial Court (Criminal Division) for the judicial district of York-Metropolitan Toronto. Nelles was charged with four counts of first degree murder. At the onset of the trial, the provisions of the Criminal Code were related:

> S. 205(1) A person commits homicide when, directly, or indirectly by any means, he causes the death of a human being.
> (2) Homicide is culpable or not culpable.
> (3) Homicide that is not culpable is not an offense.
> (4) Culpable homicide is murder or manslaughter or infanticide.
> (5) A person commits culpable homicide when he causes the death of a human being,
> (a) by means of an unlawful act . . .
>
> S.212 Culpable homicide is murder,
> (a) where the person who causes the death of a human being
> (i) means to cause his death; or
> (ii) means to cause him bodily harm that he knows is likely to cause his death and is reckless whether death ensues or not.
>
> S.214(1) Murder is first degree murder or second degree murder.
> (2) Murder is first degree murder when it is planned and deliberate. (Cited in R. v. Nelles, 1982, pp. 2-3)

The hearing lasted a total of 45 days and over 100 witnesses testified, including expert testimony in regards to the effects of digoxin, both before and after death. Dr. Alois Hastreiter, Director of Paediatric Cardiology, University of Illinois Hospital, stated:

> . . . I would like to first say that any questions related to the amount of drug administered or the time of administration of the drug, is always a difficult question to answer and that an error may be involved in these calculations and assumptions have to be made. Therefore, it should be made very clear that we're dealing here with possibilities rather than certainties. (R. v. Nelles, 1982, p. 28)

At the conclusion of the trial, Justice D. Vanek stated:

> From my assessment of the evidence before me in this case I come to the following conclusions:
> 1. The evidence is extremely circumstantial;
> 2. There is no evidence of any motive;
> 3. In the case of . . . there is no evidence to go before a jury that the accused was the person who murdered this child;
> 4. While the accused had access to each of the [infants] and therefore an opportunity to administer the dosage of digoxin that caused death, in none of these cases did she have exclusive access and opportunity; in each case other persons also had access to each of these infants at relevant times and the opportunity to administer the digoxin to them that caused death;
> 5. There is no evidence of any acts or conduct on the part of the accused in relation to any of the four babies that is out of the usual course of her duties as a registered nurse at the hospital, or which isolates and identifies her as the person who caused death by the administration of overdoses of digoxin to any of them;
> 6. The accused is an excellent nurse and enjoys an excellent reputation among her peers;
> 7. Each item or piece of evidence in support of the Crown's case, if consistent with guilt, is equally consistent with a rational conclusion, grounded in the evidence, that the accused is

> not the guilty person;
> 8. In addition, there is powerful evidence in disproof of the allegation that the accused is the person who caused the death of the four babies;
> 9. There is evidence that points in a different direction . . .
>
> In my opinion, therefore, upon the whole of the evidence, no sufficient case is made out to put the accused on trial on any of the four charges included in the three Informations before me.
>
> Accordingly, with respect to each count, the accused must be discharged. (R. v. Nelles, 1982, pp. 79-83)

Nelles was discharged on May 21, 1982. Following Nelles' discharge, the Lieutenant Governor in Council authorized a review of the practices and procedures in the Sick Children's Hospital. The review was undertaken by the Honourable Mr. Justice Dubin and a committee of hospital and medical experts. In January 1983, the committee submitted a 236 page report, which included 98 recommendations. The report concluded that "notwithstanding the incidents which occurred in the past, the quality of the hospital services was excellent and the staff highly qualified" (Charbonneau, 1985, p. 15).

A further investigation was carried out conjointly by the Ontario Ministry of Health and the United States Center for Disease Control. Upon considering the evidence from the Dubin report, the investigation carried out by the Ontario Ministry of Health and the United States Center for Disease Control, and the evidence from the preliminary inquiry conducted against Nelles, the Attorney-General concluded:

. . . that there would be no further criminal charges laid at that time against any person or persons for there was insufficient evidence to support them. However, responding to the requirement of accountability to the public, the Attorney-General determined that there should be a Royal Commission of Inquiry to look into and report publicly on the circumstances surrounding the deaths of the children and the subsequent criminal proceedings against Miss Nelles. Accordingly, on April 21, 1983 the Lieutenant-Governor in Council ordered that a commission be issued to the commissioner. The Order-in-Council is set forth in full:

WHEREAS concern has been expressed in relation to a number of deaths of infants in Cardiac Wards 4A and 4B at the Hospital for Sick Children, Toronto, between July 1st, 1980 and March 31st, 1981, and
WHEREAS concern has been expressed concerning the functioning of the justice system in respect to the instituting and of prosecuting of charges in relation to the said deaths, and
WHEREAS the Government of Ontario is of the view that there is a need for the parents of the deceased children and the public as a whole to be informed of all available evidence as to the deaths and the proceedings arising therefrom, and
WHEREAS it is thought fit to refer these concerns to an inquiry pursuant to the provisions of the Public Inquiries Act, R.S.O. 1980, Chapter 411,
Now THEREFORE, pursuant to the provisions of the said Public Inquiries Act, R.S.O. 1980, Chapter 411, a commission be issued to appoint the Honourable Mr. Justice S. G. M. Grange who is, without expressing any conclusion of law regarding civil or criminal responsibility:

1) to consider the matters disclosed in the Report of the Hospital for Sick Children Review Committee, chaired by the Honourable Mr. Justice Charles Dubin; the report on 'Mortality on the Cardiology Service in a Children's Hospital in Toronto, Canada' by the Center for Disease Control and the Ontario Ministry of Health; and the evidence disclosed at the preliminary hearing in relation to the charges of murder relating to the death of four infants at the Hospital for Sick Children and, having regard to the undesirability of duplicating unnecessarily the work done by them or unnecessarily subjecting witnesses to further questioning, to draw from such reports and preliminary hearing whatever evidence which he deems relevant and appropriate and to thereby dispense with the

> hearing of any testimony and production of documents or things that he considers appropriate;
>
> 2) to require the summoning of such witnesses as the Commissioner deems necessary to give evidence under oath and to produce such documents and things as the Commissioner may deem requisite to the full examination of the matters he is appointed to examine and to ensure full public knowledge of the completeness of the matters referred to in these terms of reference;
>
> 3) to inquire into and report on and make any recommendations with respect to how and by what means children who died in Cardiac Wards 4A and 4B at the Hospital for Sick Children between July 1st 1980 and March 31st, 1981, came to their deaths;
>
> 4) to inquire into, determine and report on the circumstances surrounding the investigation, institution, and prosecution of charges arising out of the deaths of the above mentioned four infants;
>
> AND THAT all Government Ministries, Boards, Agencies and Commissions shall assist the Honourable Mr. Justice to the fullest extent in order that he may carry out his duties and functions, and that he shall have authority to engage such counsel, investigators and other staff as he deems it proper at rates of remuneration and reimbursement to be approved by the Management Board of Cabinet in order that a complete and comprehensive report may be prepared and submitted to the Government,
>
> AND THAT the Ministry of the Attorney General will be responsible for providing administrative support to the Inquiry,
>
> AND THAT Part III of the said Public Inquiries Act be declared to apply to the aforementioned Inquiry. (Nelles et al. and Grange et al., 1984, pp. 84-85)

The inquiry lasted a total of 191 days at a cost of three million dollars (Charbonneau, 1985, p. 14). The report concluded that:

> . . . eight of 36 babies who died at the hospital between June 1980 and March 1981 were given deliberate overdoses of the . . . heart drug digoxin. A further 15 deaths are suspected to have been caused by deliberate digoxin overdoses. (Charbonneau, 1985, p. 16)

There were no conclusions drawn by the Commission as to how the murders occurred (if indeed they were murders), "what the motive was, or what steps should be taken to ensure that it never happens again" (Charbonneau, 1985). Several medical experts following the release of the report questioned "Judge Grange's conclusions on the accuracy of digoxin testing" (Charbonneau, 1985, p. 18). Charbonneau (1985) summarizes the opinions of several experts:

> Dr. Albert Burton, a biochemist at the University of British Columbia, says that a study he did of 13 of the 36 infants whose deaths were probed at the inquiry showed that the average digoxin levels were actually lower than those of a group of babies from the United States who died of natural causes. . . . Other researchers, including Dr. J. C. Russell at the University of Alberta and Dr. Stephen Soldin at the Hospital for Sick Children, have also questioned whether babies were murdered with drug overdoses, saying the high digoxin levels could have been caused by the heart drug interacting with other drugs given to the infants. (Charbonneau, 1985, p. 18)

Dr. Russell, University of Alberta, also pointed out that:

> . . . the character of the scientific approach to truth and understanding . . . is not compatible with the adversarial process of the legal world . . . the legal authorities may not have fully comprehended the limits of science and the divergence of opinion on the accuracy of digoxin testing. (Charbonneau, 1985, p. 18)

What is so devastating about this case is that there are still no answers. Reputations were ruined, private lives disrupted, nurses questioned their professionalism and their very "being." The psychological and economic strain on nurses who were involved was horrendous. There can never be any compensation for the suffering, humiliation and pain that was endured by all parties involved.

Summary

In this chapter, a general overview of the Canadian legal system was presented. This was followed by an examination of negligence and the types of liability, i.e., direct and vicarious. The literature incorporating specific concerns to nurses such as standard of care, documentation and failure to provide adequate coverage was then examined in the Canadian context. Where appropriate, specific case examples were provided.

As the purpose of this chapter was to determine the types of nurse behaviours which resulted in negligence lawsuits, an analysis of specific cases related to civil lawsuits and negligence, civil lawsuits and dismissal cases, and a discussion of a criminal lawsuit and public inquiry into the deaths of children at Sick Children's Hospital in Toronto were reviewed.

One of the major points stressed throughout this chapter was that nurses are responsible and accountable for their actions. Each nurse has legal responsibilities, employment responsibilities, and professional responsibilities. The first responsibility of the nurse is to provide a high standard of care and a safe environment for the patient. The nurse of the 80's requires acute assessment and observation skills, an ability to perform all procedures in a safe and competent manner, a high knowledge-skill base in regards to medications and their effects, and an ability to document in a concise and accurate manner. If there was any advice to be gleaned from this chapter, it is that nurses are required to: carry out their duties in a safe and competent manner, update their knowledge-skill base and skills on a continual basis, and document patient care with diligence. In addition, nurses should not carry out a procedure for which they have not received educational training or practise unless they are under the direct supervision of a clinical instructor or supervisor who is familiar with the procedure.

In the following chapter, arbitration cases will be examined with particular emphasis on the types of nurse behaviours which result in suspension or termination from employment.

Chapter 5

ARBITRATION CASES: SUSPENSION AND TERMINATION FROM EMPLOYMENT

Introduction

The purpose of this chapter is to determine from arbitration cases the types of nurse behaviours which resulted in suspension or termination from employment and the arbitral consequences of these behaviours. This is done in several steps. First, an overview of dismissal for 'just cause' is presented, outlining a definition of 'just cause,' historical underpinnings and legislative enactments. Second, the process of grievance arbitration is reviewed. Third, general considerations in arbitration cases are discussed focusing on the following topics which are of relevance to this study: prior record of the employee, culminating incident, organizational rules and regulations, progressive discipline, probationary employees, and the concept of quit or discharge. This is followed by a selected review of arbitration cases which have resulted in the suspension and termination from employment of nurses in Canada.

In 1983, the researcher and a colleague in a chapter of a book titled, "Cooperation and Conflict," assert that:

> The discipline of professional employees raises a number of complex questions for industrial relations

> experts. . . . The most severe disciplinary penalty--the dismissal of an employee--is regarded by union leaders as the 'capital punishment' of labour relations. Accordingly, the termination of a nurse by an employer, for whatever reason, will be vigorously challenged by the negotiating body. The negotiating body is obligated to defend the negotiated rights of the disciplined member and will file a grievance calling for investigation and reinstatement of the individual nurse. If the dismissal has occurred as a result of alleged unprofessional misconduct, incompetence or negligence, the matter will most probably be referred to the professional body for investigation by a disciplinary committee. Because of the seriousness of the allegations and the implications for the individual nurse, it is essential that both organizations act in the best interest of that nurse. . . . The individual nurse caught up in such a situation may feel frustrated and confused by the conflicting deliberations on her behalf. (p. 88)

These statements identify the depth, breadth and complexity of the situation that arises when discipline of a professional by an employer is dealt with in the context of an industrial relations system. In most instances of "dismissal for just cause" that involves incompetence, professional misconduct (falsification of records, theft, breach of confidentiality, patient abuse, criminal connections), drug or alcohol related matters, and medication errors, the individual nurse will be reported to the professional association. This body will then be responsible for deciding whether: (1) charges will be dismissed, (2) the nurse requires counselling and/or further educational courses, (3) a suspension is required, or (4) the license will be revoked. At the same time, the nurse who is covered under a collective agreement will most likely file a grievance about the dismissal and thus follow the steps of the grievance procedure as outlined in the collective agreement. The system as it stands today is fraught with problems. In a few situations, an arbitrator has ordered a nurse to be reinstated to her present situation only to find that the nurse's license has been suspended and she is unable to return to work until the suspension period has expired. In another situation, an arbitrator upheld a dismissal of a nurse for a medication error even though the professional association reviewed the case and felt that no further action was warranted since the nurse had performed what a "reasonable and prudent" nurse was expected to do under the circumstances. At a recent labour relations seminar a leading expert in labour relations and arbitration was questioned as to whether he was aware of the problem inherent in the discipline of professionals and how could these problems best be dealt with. His reply was, "Yes there are problems but I do not have the answers as to how we go about solving them" (Personal communication from a labour arbitrator, October 15, 1986).

Dismissal for "Just Cause": An Overview

In this section, an overview of dismissal for 'just cause' is provided in order to present background information for the reader. A definition of 'just cause' is first reviewed. This is followed by a brief discussion of historical underpinnings and legislative enactments which have had a major impact on the involvement of Canadians in collective bargaining since it allowed individuals the right to form unions of their choice and offered protection against unfair labour practices.

Definition of Just Cause

The majority of collective agreements in Canada contain a clause which states that an employee may not be terminated from employment without 'just cause.' In the Steep Rock Iron Mines case, an arbitrator explains this concept.

> 'Just cause' means well-grounded, fair, equitable, proper. 'Cause' means ground or reason--adequate justification. If a company is to discipline for 'just cause' it is obliged to satisfy in the final stage of the grievance procedure, that is, the board of arbitration, that such "just cause" existed at the time of the handing out of the discipline. In other words, in a case of this kind the company must establish affirmatively the existence of grounds upon which it has chosen to act. (pp. 148-149)

One of Canada's most prominent arbitrators, Bora Laskin, comments on the complexities involved in determining whether an individual has been terminated for 'just cause':

> Arbitration decisions on just cause reflect very clearly the infinite variations in fact that move arbitrators to find just cause in some cases and not in others. Principle, in the sense, of crystallization of fact situations, is possible only where the relevant is separated from the irrelevant and the judgement on the residue hopefully is announced as an expression of a general rule. What is relevant and what is irrelevant in a context of

> collective bargaining and collective agreements will not always command general acceptance. This is obvious from reading decisions of labour arbitration boards in the United States as it is in reading those of Ontario boards or those in other provices. (Cited in Palmer, 1983, p. 232)

Historical Underpinnings: Common Law

The statutory requirement to provide notice and show "just cause" for a dismissal originated in the feudal legislation enacted in England c. 1562. Harris (1980) outlines the origins:

> . . . the Statute of Labourers (known specifically as 'An Act containing direct orders for Artificers, Labourers, Servants of Husbandry and Apprentices' (1562), 5 Eliz. I, c.4). Among its provisions, the Statute authorized the imprisonment and whipping of a servant who prematurely abandoned his lord's service (s.11). . . . Had the servant elected to leave the employ before his work was finished he would have done so at the risk of one month's imprisonment (s.14). An unmarried woman from the age of 12 to 40 years may have been appointed to serve a master for the wages he deemed reasonable, being committed should she refuse (s.24). . . . Section 5 of the Act sets out the requirement to show cause to effect a dismissal:
>
> > And be it further enacted That no person which shall retain any servant, shall put away his or her said servant, and that no Person retained according to this Statute, shall depart from his Master, Mistress, or Dame, before the End of his or her term, upon the Pain hereafter mentioned, unless it be for some reasonable and sufficient Cause or Matter to be allowed before two Justices of Peace or one at least within the said County, or before the Major or other Chief Officer of the City, Burough or Town Corporate wherein the said Master, Mistress or Dame inhabiteth, to whom any of the parties grieved shall complain; which said Justices or Justice, Mayor or Chief Officer, shall have and take upon them or him the hearing and ordering of the Matter betwixt the said Master or Mistress, or Dame and Servant, according to the Equity of the Cause. (pp. 1-2)

Employees no longer face imprisonment or a whipping for abandoning their employment, however some of the principles inherent in this statute exist today. These principles are as follows:

1. a responsibility on the part of the employee to notify the employer of his intent to resign;

2. a responsibility on the part of the employer to notify the employee of his dismissal; and

3. a grievance procedure.

Legislative Enactments

Prior to the "advent of collective bargaining, the courts heard and resolved disputes involving contracts of employment" (Brown & Beatty, 1984, p. 21). Several years ago, the investigator outlined the historical antecedents of collective bargaining, with particular reference to registered nurses (Botterill-Conroy, 1980). One of the most significant occurrences in the Canadian scene was the enactment in 1944 of Privy Council Order No. 1003 (P.C. 1003). The essential features of this Order-in-Council included:

1. the right of employees to form unions;
2. protection against unfair labour practices which, if allowed to continue, would result in discouraging the exercise of the right to form and join unions;
3. a system for defining bargaining units and certifying bargaining representatives;
4. compulsory collective bargaining;
5. compulsory postponement of strikes and lockouts coupled with compulsory two-stage reconciliation;
6. the right to resort to strikes and lockouts

> after compulsory conciliation procedures were completed;
>
> 7. compulsory negotiation and arbitration, if necessary, of disputes arising during the life of the agreement. (Woods, 1973, p. 93)

Basically, these main characteristics are still found in the provincial and federal legislation, with the exception of British Columbia and Quebec. Saskatchewan adopted compulsory collective bargaining but did not incorporate compulsory conciliation and arbitration features into its trade union legislation.

The enactment of P.C. 1003 allowed individuals to join trade unions of their choice. Further, a

> distinctly Canadian characteristic of our law is that collective agreements provide for arbitration of disputes arising during their term, and that there by no strikes or lockouts at this time. (Brown & Beatty, 1984, p. 3).

The Grievance Arbitration Process

Introduction

The purpose of this section is to outline the grievance arbitration processes. First, the basic types of grievances are discussed. Second, the grievance process is presented. Third, the arbitration process is reviewed with particular reference to the appointment of the arbitration tribunal, the hearing, and the nature of the award.

The collective agreement specifies the procedure to be followed in the event of a dispute arising. This process is referred to as grievance arbitration. The types of grievances brought forward are far-ranging. Palmer (1983) describes four basic types:

> (a) individual employee grievances where the subject-matter of the grievance is personal to the employee;
> (b) group grievances where a number of employees with individual grievances join together in filing their grievances, thus really being an accumulation of individual grievances;
> (c) union or policy grievances where the subject matter is of general interest and where individual employees may or may not be affected at the time that the grievance is filed;
> (d) a hybrid type of grievance which is a combination of the policy grievance and the individual grievance. In this type of situation, although one individual may be affected, he may be affected in such a way that is of concern to all members of the bargaining unit. Thus, the individual may grieve on the basis of how he is particularly affected while the union may also grieve; citing the individual case as an example of how certain conduct may affect the members of the bargaining unit generally. (p. 175)

The Grievance Process

The steps of the grievance procedure are outlined in the collective agreement. In some provincial jurisdictions in Canada, the union bargains on behalf of all nurses (province-wide bargaining), and therefore all nurses are governed by one collective agreement. It should be noted that even though the agreement specifies the steps, a hospital may have an addendum which outlines the steps in that particular hospital.

In essence, if the matter cannot be resolved through informal channels, then the process follows a series of steps. The grievance procedure in the collective agreement between the Saskatchewan Union of Nurses and the Saskatchewan Health Care Association (1986) is used as an illustration.

Step 1: The grievance is referred in writing to the Director of Nursing. The grievance contains the following information: (a) the nature of the grievance and the circumstances out of which it arose; (b) the section or sections of the agreement violated; and (c) the remedy that is being requested. The Director of Nursing has seven days within which to reply.

Step 2: If the grievor feels that the answer from the Director of Nursing is unsatisfactory, then the matter will be referred to the Administrator of the hospital who has seven days within which to reply (article 16.10, 16.11).

Step 3: If the dispute remains unsettled, the grievor may refer to the matter to the board of the hospital for resolution. The hospital board has seven days within which to reply (article 16.12, 16.13).

Step 4: If the grievance still remains unsettled, then the matter is typically referred to arbitration.

The timeliness for submitting the grievance to the appropriate party is important. Several legitimate grievances have not been heard because nurses were not aware that this avenue was open to them or that they had specified timelines in which to file the grievance. At each of the steps (including the informal means), the individual has the right to representation by the union, either the president of the local or an employee relations officer. At the hearings associated with each step of the grievance process, members from management and the union are present to discuss their concerns. The final step in the process is typically arbitration.

The Arbitration Process

In relation to the arbitration process, Brown and Beatty (1983) state:

> . . . Grievance arbitration is an adjudicative process through which disputes arising out of the application and operation of a collective agreement are finally resolved. As such, it performs the same function for the parties to a collective agreement as do the courts in resolving issues and disputes arising from the operation of contracts in society generally. In essence it is a private, quasi-judicial system created for each collective bargaining relationship. (p. 1)

The process commences with the appointment of an arbitration tribunal and concludes with the arbitration tribunal's award. The dispute may be heard by a sole arbitrator or a panel, however, once the award is handed down the award is final and binding. Several authors describe the process in detail (Brown & Beatty, 1984; Gorsky, 1981; and Palmer, 1983).

Appointment of the arbitrator or arbitration tribunal. The collective agreement stipulates the procedure to be followed in the selection of an arbitrator or arbitration board. If the collective agreement is silent, then the labour relations act in each provincial jurisdiction will set out the procedure to be followed. In some cases, a sole arbitrator will hear the case. However, it is customary for the union to appoint one nominee, the employer to appoint a nominee and for these individuals to choose a chairman. There is usually a further stipulation that if the two members named by the respective parties cannot agree on a chairman, then either the Minister of Labour, the Labour Relations Board or the Chief Justice of the Court of Queen's Bench may appoint the third member.

The hearing. The arbitration hearing is conducted in a quasi-judicial form. Each party presents opening statements, calls forth witnesses who are subject to cross-examination by the other party and presents a final argument. In most instances the testimony is taken under oath. Any testimony which is relevant to the issue, whether hearsay or opinion, will be accepted. In discharge cases, a trend has developed whereby the onus is on the employer to present their argument first.

> . . . Arbitrators and boards of arbitration . . . have usually ruled that in discharge cases the employer should proceed first. This has been the case for a great many years, and it is in my view, the correct one. Although in proceedings before the courts it is often, though not always, regarded as an advantage to proceed first, in labour-management arbitrations going first is, for reasons which are not altogether clear, regarded as somewhat objectionable. The general rubric that "he who asserts must prove" is often put forth as a reason for unwillingness to proceed. This general principle

> is valid enough but its application in cases such as this leads me to the conclusion that it is the employer who should proceed first. (Massey Ferguson, 1969, pp. 179-180)

The nature of the award. The arbitration tribunal usually considers many factors when arriving at a decision. These factors were addressed by the investigator in a paper titled, Labour Relations and Nursing (Botterill-Conroy, 1980).

1. the prior record of the employee;
2. the length of service of the employee;
3. whether the offense was an isolated incident;
4. whether the offense was committed on the spur of the moment or whether the offense was premeditated;
5. whether the penalty has created a particular hardship for the employee;
6. evidence that the company rules of conduct, either verbal or written have been uniformly enforced;
7. the seriousness of the offense;
8. other relevant circumstances. (pp. 189-190)

The arbitration tribunal usually reviews other relevant cases in assessing the final decision. Of particular note is the fact that nurses by nature of their work and the possibility that their actions may have life and death consequences are expected to have a higher standard of conduct:

> A much higher standard of conduct is expected from employees in the health care field than in other occupational fields. In this industry arbitrators are required to have regard not only to the interests of the grievor and of the employer but also must have regard to the public interest. Both employer and employee are reposed with a public trust for which they are held accountable. (Baptist Housing Society (Grandview Towers) and Hospital Employees' Union, 1982, p. 437)

In this section, background information has been provided. A general overview of dismissal for 'just cause' was presented followed by a review of the grievance and arbitration process. In the following section, general considerations in arbitration cases are reviewed with particular focus on those areas of concern to registered nurses.

General Considerations in Arbitration Cases

The areas viewed to be of relevance to this study, since these considerations relate to the suspension and termination from employment of nurses, are: prior record of the employee; culminating incident; organizational rules and regulations; progressive discipline with particular emphasis on warnings, performance appraisals and anecdotal records; probationary employees; and the concept of 'quit or dismissed.' Where relevant, specific cases involving the suspension and termination from employment of nurses have been presented.

Prior Record of the Employee

One of the central issues to be decided upon by arbitrators early in the hearing of a dismissal case is whether information from the employee's record can be used. An employer may use this record in discharge cases, provided that the employee is made aware of the record and what is there and that this information may be used in future disciplinary action.

> There is a strong tendency in discharge cases for over-emphasis on the last incident. In many cases this is merely the incident which precipitates the discharge but the cause lies in a pattern of conduct which has shown that the employee is unsuitable for his job. If the company concerned could not discharge an employee 'for cause' unless one single incident constituted cause it would in many cases be obliged to retain in its employ workers who could repeat with impunity minor infractions of the rules and generally perform in an unsatisfactory manner. An employee's performance can, therefore, be taken into consideration by a board of arbitration in determining whether he is "suitable" or "unsuitable" and in the course of so doing the board must carefully weigh and assess the evidence of the witnesses for both sides in reaching its conclusion. (Standard Dairy, 1961, p. 40)

Most arbitrators also take the position that once a final decision has been made by management any further disciplinary action cannot be taken with the employee unless he commits another further act or new facts are brought to the employer's attention (Palmer, 1983, p. 284). For example, a nurse was suspended and shortly thereafter received her dismissal. The board ruled that:

> . . . the three day suspension was designed to provide a time period in which [the grievor] could decide which route she wanted to take. In these circumstances, where no final decision as to the disciplinary penalty has been made by the employer, who may be undertaking a more comprehensive investigation of the events, seeking legal advice or examining the employee's employment in closer detail, it is not unusual for the employee to be suspended pending a final decision or discipline. The cases do not amount to double jeopardy unless the evidence shows that the employer communicates to the employee or the union that the suspension is final or a maximum penalty for the offense. (Mission Memorial Hospital and Registered Nurses' Association of British Columbia, 1980, p. 11)

Culminating Incident

The doctrine of the culminating incident "delineates those circumstances in which it is proper for the employer to consider an employee's past employment records in matters pertaining to discipline" (Brown & Beatty, 1983, p. 475). Palmer (1983) points out that "although the general concept of a 'culminating incident' has been widely accepted, there is some difficulty in stating exactly what a culminating incident is" (p. 286). One arbitrator summarizes the doctrine as follows:

> . . . it seems clear to me that there is no special 'doctrine of culminating incident' separate from ordinary principles developed to govern disciplinary grievances. In all cases where a grievor challenges discipline imposed as the immediate result of alleged particular conduct arbitrators proceed this way: If they find the conduct not established by the evidence or, if established, not warranting a penalty, they allow the grievance and grant the fullest remedy. But, if they find the conduct established and warranting some penalty, they examine the grievor's total record, both good and bad, to determine in the light of all the circumstances whether the particular penalty levied fits the wrong, and, if not, the nature of the penalty fitting better. (Canadian Lukens Ltd., 1976, p. 439)

In the arbitration case involving Flin Flon General Hospital and Flin Flon Nurses, Manitoba Organization of Nurses' Association (1981), the arbitration board upheld the dismissal of a nurse as a result of a 'culminating incident.' The nurse had been employed in the hospital from 1974. During the period 1974-1976 she received good performance appraisals, however, in 1977 derogatory complaints were made about her behaviour to other staff and patients. The vernacular used was an "extreme case of RNitis" (pp. 9-10). The culminating incident took place on December 24, 1979 when the nurse refused to accept care for a patient. The arbitration board concluded:

> . . . professional ethics and standards would seem to demand that hospital staff do not ever refuse, or even demur when it comes to patient care, but may, if in difficulty, seek alternatives or assistance . . . in any event I am satisfied that a clear order was given, that order was unequivocal, but the grievor demurred or argued in its execution to such as degree as to amount to a refusal, or at least a serious apprehended interruption of patient care. (p. 15)

Nurses should be aware that if their behaviour warrants a penalty, an arbitrator may utilize the information contained in their previous performance appraisals to assess the penalty imposed.

Organizational Rules and Regulations

There are a number of situations where an "employer has disciplined an employee for an offense which that employee was not warned or for which no rule was promulgated" (Palmer, 1983, p. 279). Clearly, there are situations where no rules are required to discipline an individual, for example, drinking on the job, theft, criminal charges which would have an effect on the employee's ability to carry out his duties (such as theft of narcotics from the hospital, sleeping on the job, and insubordination).

In one particular case, Council of Brewers' Warehousing Workers and Brewers' Warehousing Company Ltd.

(1955), a board of arbitration reinstated an employee because of technicalities in the wording of the company rule. The rule had been unilaterally introduced and "prohibited drinking during working hours." The main concern of the board

> . . . was that whenever an employee's actions are to be regulated by the unilateral decision of a company the employee must be made aware of those regulations. It is thus a twofold issue: (1) the notice must be clear and unequivocal language; and (2) the notice must be brought to the attention of the employee. (p. 216)

The board concluded that the company rule did not specify clearly whether "working hours" included the lunch hour. It should be noted that this situation was in industry and not in the health care field. In the section on legal liability, nurses were held to be negligent even when on their coffee breaks since they had a responsibility to ensure that patient care is adequately provided for prior to leaving on breaks.

Arbitrators have used these guiding principles:

> I. Characteristics of Such Rules
>
> A rule unilaterally introduced by the company and not subsequently agreed to by the union, must satisfy the following requisites:
>
> 1. It must not be inconsistent with the collective agreement.
> 2. It must not be unreasonable.
> 3. It must be clear and unequivocal.
> 4. It must be brought to the attention of the employee affected before the company can act on it.
> 5. The employee concerned must have been notified that a breach of such rule could result in his discharge.
> 6. Such rule should have been consistently enforced by the company from the time it was introduced.

> II. Effect of Such Rule re Discharge
>
> 1. If the breach of the rule is the foundation for the discharge of an employee such rule is not binding upon the board of arbitration dealing with the grievance, except to the extent that the action of the company in discharging the grievor, finds acceptance in the view of the arbitration board as to what is reasonable or just cause.
> 2. In other words, the rule itself cannot determine the issue facing an arbitration board dealing with the question as to whether or not the discharge was for just cause because the very issue before such a board may require it to pass upon the reasonableness of the rule or upon other factors which may affect the validity of the rule itself.
> 3. The rights of the employees under the collective agreement cannot be impaired or diminished by such a rule but only by agreement of the parties. (Cited in *Lumber and Sawmill Workers' Union, Local 2537 and KVP C. Ltd.*, 1965, pp. 85-86)

One of the most contentious cases involved the dismissal of a registered nurse for sleeping on the job (neglect of duty). During the hearing the Director of Nursing testified that she viewed sleeping on duty as a "matter involving gross violation of hospital regulations and professional conduct and as an extremely serious neglect of duty" (*Halifax Infirmary Hospital and Nurses' Staff Association of the Halifax Infirmary Hospital*, 1976, p. 9). This topic is rarely discussed, however many nurses would testify that they have either slept or "dozed off" during breaks or have known someone that has. In assessing this particular case, the arbitration board examined the question of whether a nurse has the right to sleep during breaks. There were no written rules to suggest that nurses who were found sleeping would be disciplined. The arbitration board found that there was "no evidence to suggest that it has ever been the custom for nurses to sleep while on breaks" (Halifax Infirmary Hospital and Nurses' Staff Association of the Halifax Infirmary Hospital, 1976, p. 18). The arbitration board upheld the dismissal. This case will be discussed further in the case review under neglect of duty.

Nurses should be aware of the rules and regulations in their particular organizational setting.

Progressive Discipline: Warnings, Performance Appraisals, Anecdotal Records

Discipline in the work environment is not meant to be punitive in nature, but rather is a means by which corrective action can be undertaken. The investigator discussed these steps in an article titled, "Discipline: Know Your Rights." The steps are as follows:

1. Verbal discussions with the employee as to the problem, the relevant rules and regulations, and to possible solutions;
2. Letters of warning, counselling memorandum and/or written guidelines;
3. Suspension for a specified period; and
4. Dismissal (Steven, 1986a, p. 1).

The advantage cited for using the progressive discipline approach is:

> . . . that it enables the parties to know where they stand with each other. An employer who is subjected to corrective discipline knows that after receiving a

> warning he may receive a suspension and that after a suspension he may be discharged if he repeats an offense. (North York General Hospital, 1973, p. 45)

In essence, verbal reprimands are not considered to be disciplinary in nature. To be "considered discipline, the warning must be one creating tangible loss in the future" (Palmer, 1983, p. 249).

In the arbitration case involving Mount Sinai Hospital and Nurses' Association, Mount Sinai Hospital (1976), a nurse filed a grievance in regards to a "warning" which was contained in her evaluation. The performance evaluation contained a number of observations of her work performance with which the nurse disagreed. The case was ultimately dismissed on the grounds that it was inarbitrable, however, the arbitration board presented a comprehensive discussion on what types of action are considered disciplinary in nature. During the hearing, the hospital put forth the argument that:

> . . . the purpose of the evaluation was to make an assessment of an employee's work performance which assessment would serve to communicate to the employee the evaluator's opinion of her work performance, and if necessary provide an opportunity for an explanation and a redefinition of the expectations of the department with regards to the nurse's work performance. The [supervisor] also stated that the evaluation was used for the purpose of counselling the nurse, for the purpose of assisting the nurse in identifying various problems she was having with her work performance and offering suggestions as to how to resolve them. (p. 105)

The arbitration board contended that:

> . . . by classifying the action . . . as directed towards education and self-improvement, in other words as corrective in nature . . . does not

> necessarily succeed in removing it from the classification of actions which are disciplinary in nature. (pp. 105-106)

The question then becomes what constitutes disciplinary action. The board used an illustration, a similar case, Corporation of County of Norfolk and London and District Building Service Workers (1972), whereby that board addressed this issue:

> . . . Not all forms of disapproval shown by an employer constitute 'discipline' for the purposes of adjudication by arbitration. Although a complete definition of what constitutes 'discipline' may be difficult to achieve, it is manifest that one element is that the action claimed to be 'discipline' must form part of the employee's record. (Cited in Mount Sinai Hospital and Nurses' Association, Mount Sinai Hospital, 1976, p. 108)

Therefore, in order for the action to be considered disciplinary in nature, it must form part of the employee's record. The issue then becomes one of whether or not the performance appraisal is part of the employee's record. Another case pursues this question. In the arbitration case involving Saskatoon City Hospital and Saskatchewan Union of Nurses (1982), the arbitrator clearly outlined the objectives of a performance appraisal:

> (1) To evaluate the abilities of an employee for the purpose of assisting the employee, through training to develop those abilities;
> (2) To provide an inventory of skills to assist the present supervisor in the allocation of the workload;
> (3) To provide profiles on employees for orientation of future supervisors;
> (4) To provide profiles on employees for outside references;
> (5) To evaluate employees for future promotions and

> opportunities;
> (6) To evaluate the employee for future discipline;
> (7) To evaluate the employee for immediate discipline or reward. (pp. 6-7)

The matter concerning whether the performance appraisal or evaluation is disciplinary in nature or not was also addressed in this case as follows:

> . . . the issue of whether an evaluation is disciplinary or non-disciplinary in nature is a question of fact in each circumstance. Generally, when management clearly indicates that an evaluation is non-disciplinary in nature, boards of arbitration accept such statements as determinants of the issue, unless there is evidence to the contrary. Where an evaluation is non-disciplinary in nature, one would expect full disclosure of the contents of the evaluation to the employee, since assisting the employee is its sole and only purpose. As well, it is hard to see why a performance evaluation would be retained in an employee's personnel file if it is purely non-disciplinary. Once the evaluation has been completed and passed on to the employee with suggestions of corrective procedures, the retention of the evaluation starts to take on the flavour of a disciplinary document, because as a non-disciplinary document, it has served its purpose. Its retention must be for future reference or for future assessment of the employee. This suggests that the changes suggested arising out of the evaluation must be carried out by the employee or else something negative to the employee will occur. Once this dimension is added to the evaluation process, it becomes disciplinary in nature. (pp. 9-10)

The performance appraisal only becomes disciplinary in nature once it is filed. The critical point here is that if any type of written discipline (warning letter, memorandum, performance appraisal) contains derogatory comments, an individual should file a grievance if it is placed on the personnel files. Once it is placed on the file it may be utilized in future disciplinary actions, as clearly illustrated in the arbitration case involving

Kimberley-Clark of Canada Ltd. and International Chemical Workers, Local 813 (1972):

> To the extent that any warning is disciplinary, of course, the sanction inflicted upon the employee so disciplined is not immediate, but potential. The employee concerned will have in mind that if a disciplinary warning is not made the subject of a successful grievance, the 'warning' will go on to 'build a record' that may be used against him at a later date should he subsequently be dismissed or suspended or subjected to some other form of discipline. A warning can fairly be characterized as a disciplinary warning, that is to say, when it may have a prejudicial effect upon the employee's position in future grievance proceedings to contest a dismissal or suspension or other disciplinary action.
>
> On the other hand, company personnel records might well include a memorandum of some sort containing unflattering remarks about an employee, but which could not be viewed as a disciplinary warning in the sense of laying the basis for, or supporting, other disciplinary measures at a later date--either because of the nature of the document, or because the 'warning' was not brought to the attention of the employee in such a way as to afford him the opportunity of challenging it through the grievance procedure, or because it is clear for some other reason that the employee would not be prejudiced in any future proceedings by having failed to grieve the 'warning' immediately following its issuance. (Cited in Mount Sinai Hospital and Nurses' Association, Mount Sinai Hospital, 1976, p. 108)

The discussion surrounding warnings, performance appraisals and whether they are disciplinary or non-disciplinary in nature appears rather ambiguous. The key point is that once an employee is given notice of any "disciplinary" action, then if the employee decides not to challenge it, or unsuccessfully changes it at an arbitration hearing, the incident may be used in future proceedings (Mount Sinai Hospital and Nurses' Association, Mount Sinai Hospital, 1976, p. 107).

Anecdotal notes, usually kept by head nurses for evaluation purposes, cannot be used for future proceedings. As concluded by the arbitration board in the arbitration case involving Mount Sinai Hospital and Nurses' Association, Mount Sinai Hospital (1976):

> . . . the anecdotal record . . . by virtue of its very secrecy . . . is useless to the hospital as a disciplinary record which could be used in subsequent disciplinary proceedings. Whichever theory of discipline that one embraces, whether it be retributive, punitive, rehabilitative, or corrective in nature, all of them require that the employee being 'disciplined' is aware of the fact. Thus it does not matter how many derogatory comments might appear in the anecdotal record. If the employee is not aware that the employer disapproves of various aspects of her behaviour these entries cannot be used against her. (p. 107)

In this section, progressive discipline with particular reference to warnings, performance appraisals and anecdotal records was reviewed. It was found that verbal reprimands are not considered disciplinary in nature, however written warnings which are placed in the employee's file or on the performance appraisal were considered disciplinary. A nurse who receives a written reprimand, memorandum, or performance appraisal which contains derogatory comments should consider filing a grievance, since once this information is placed on the file it may be used in future disciplinary action. It was also found that anecdotal records by virtue of their secrecy are useless as a disciplinary record. One of the major points stressed by arbitrators was that employees must be made aware of the particular actions that the employer disapproves of and given an opportunity to correct this behaviour.

Probationary Employees

A probationary employee who is dismissed from employment "has the right to grieve unless that right has been specifically excluded by the collective agreement" (Palmer, 1983, p. 306). The principles inherent in the dismissal of a probationary employee are as follows:

> 1. Where a collective agreement provides for a probationary status but is silent, both expressly and implicitly, as to the standards to be applied when reviewing the discharge of a probationary employee, it must be concluded that the purpose of a probationary status is to permit the employer to review the suitability of a probationary employee and that the employer need not have the same grounds for discharging a probationary employee as would be required with respect to the regular employee. The employer must be given the latitude necessary to make this assessment without the constraints that must be imposed with respect to seniority rated employees.
> 2. The onus of justifying the discharge of a probationary employee is upon the employer.
> 3. An employer is not entitled to discharge a probationary employee upon any obviously improper grounds such as race, nationality, sex, union affiliation, and the like. . . .
> 4. An employer is entitled to discharge a probationary employee because in the employer's opinion the employee is unable to meet the present and future production standards reasonably required by the employer.
> 5. However, the employer must make a fair assessment and give the employee a fair opportunity to prove his or her ability. If there has been a fair assessment and the employee has been given a fair chance to prove his or her ability, then an arbitrator ought not to interfere with the employer's conclusions that a probationary employee is unlikely to meet the standards reasonably required by the employer, even should the arbitrator reach a

> contrary conclusion. (Okanagan Manufacturers, 1977, p. 281)

The arbitrator in this case clearly outlined that the employer is not entitled to dismiss an employee on the grounds of race, nationality, sex, or union affiliation. In most provinces and the territories legislation has been enacted to protect employees from discrimination in the work force and in other areas. The Ontario Human Rights Code which was proclaimed in 1981 states:

> Every person has a right to equal treatment with respect to employment without discrimination because of race, ancestry, place of origin, color, ethnic origin, citizenship, creed, sex, age, record of offenses, marital status, family status or handicap. (s. 4[1])

Sklar (1983, pp. 51-56) provides a further discussion on protection against discrimination in the work setting. In one case reviewed, the union alleged that a nurse had been discriminated against because of a diabetic condition. A public health nurse was dismissed one week prior to the expiry of her probationary period. Up until this point her performance had been described as "most satisfactory." As part of the evaluation process, the nurse was scheduled to go out with her supervisor for two home visits. Prior to the second visit, the nurse became aware that she was undergoing symptoms of an insulin reaction and reached into her purse for dextrose tablets. The supervisor became alarmed about the nurse's extremely belligerent and uncooperative behaviour (a symptom of insulin reaction), reached into the nurse's purse but was unable to locate the dextrose tablets. The supervisor then drove the nurse to the hospital for emergency treatment.

During the arbitration hearing, the union alleged that the:

> (1) grievor had been discriminated against;
> (2) the health unit had failed to comply with a mandatory provision in the collective agreement to provide written reasons for termination; and
> (3) the decision to terminate had been taken as a result of an improper exercise of the Health Unit's discretion in that it was arbitrary, discriminatory and in bad faith. (Niagara Regional Health Unit and Ontario Nurses' Association, 1984, p. 2)

The health unit, on the other hand, expressed concern over the nurse's safety since public health nurses were required to drive an automobile as part of their duties. It is worthy to note that there is no legislation prohibiting diabetics from driving cars, although in some provinces a medical examination is required prior to renewal of registration.

The arbitration board concluded that:

1. the health unit did not discriminate against the nurse because they were aware she was diabetic upon hiring; and

2. that the health unit was not required to provide written reasons for the dismissal since the grievor was a probationary employee.

Therefore, the arbitrator upheld the dismissal of the nurse.

Resignation or Dismissal

In a number of situations, nurses have been pressured into resigning for various reasons. In the arbitration case involving the Windsor Western Hospital and Ontario Nurses' Association (1983), a nurse was placed on suspension pending investigation of an incident which occurred at the hospital on May 31, 1982. On June 8, 1982 the Director of Nursing requested that the nurse attend a meeting the following day. The nurse requested that an employee relations officer be present at the meeting, however the Director of Nursing indicated that the meeting could not be delayed. At the meeting, the Director of Nursing suggested that she sign a letter of resignation or her employment would be terminated. The nurse signed the letter reluctantly and a few hours later signed a letter withdrawing her resignation. At issue here is whether the employee resigned or was dismissed from employment.

At the arbitration hearing, the union contended that the resignation was signed involuntarily while the nurse was under extreme duress.

The arbitration board concluded that the true intent of the grievor was to resign. The board also was of the view that: (1) the grievor had been put on notice in regards to the possibility of her dismissal by the Director of Nursing during their telephone conversation of June 8; (2) the grievor was under a mistaken belief that if she resigned the hospital would not report her to the

College of Nurses (professional discipline).

Arbitrators, in general, have developed the view that

> . . . there is both a subjective and objective element to a 'quit': first, an employee must form an intent to quit his employment; and, second, he must carry out an act inconsistent with his further employment. (Cited in Palmer, 1983, pp. 271-272)

Acts that are construed as being inconsistent with continued employment include: serving notice of resignation as required in the collective agreement; turning in uniforms and/or keys; leaving work after stating "I quit" and not returning; and picking up documents that indicate termination of employment (Palmer, 1983, p. 273).

In this section, general considerations in regards to arbitration cases were reviewed. Of particular interest to nurses are: prior record of the employee; culminating incident; organizational rules and regulations; progressive discipline with emphasis on warnings, performance appraisals and anecdotal records; probationary employees and the concept of "quit or dismissal." Where applicable and relevant, arbitration cases involving nurses were described.

To summarize briefly the key points addressed in this section were as follows:

1. The prior record of the employee can only be used if the employee is aware of the contents of the record and that the information presented may be used in future disciplinary action.

2. Verbal reprimands are not considered to be disciplinary in nature.

3. In order for any action to be considered disciplinary in nature, it must form part of the employee's record, e.g., letter of warning, memorandum, performance appraisal.

4. Anecdotal records are useless as a disciplinary record because of their element of secrecy. If employees are not made aware of these entries, this information cannot be used against them.

5. Probationary employees normally are not allowed to grieve a dismissal, unless specifically stated in the collective agreement.

6. In order to constitute that an employee has resigned from a position, the employee must show intent and carry out an act which is consistent with terminating employment, for example, handing in keys and uniform.

In the following section, specific arbitration cases describing unacceptable nursing behaviour will be reviewed. In Figure 5.1, a schematic presentation for identifying unacceptable nurse behaviours is presented. The arbitration cases were divided as follows: incompetence, insubordination, neglect of duty, professional misconduct, absence, use of alcohol or drugs, dismissal on religious grounds and a miscellaneous category. Incompetence is further sub-categorized into general incompetence and medication errors. Professional

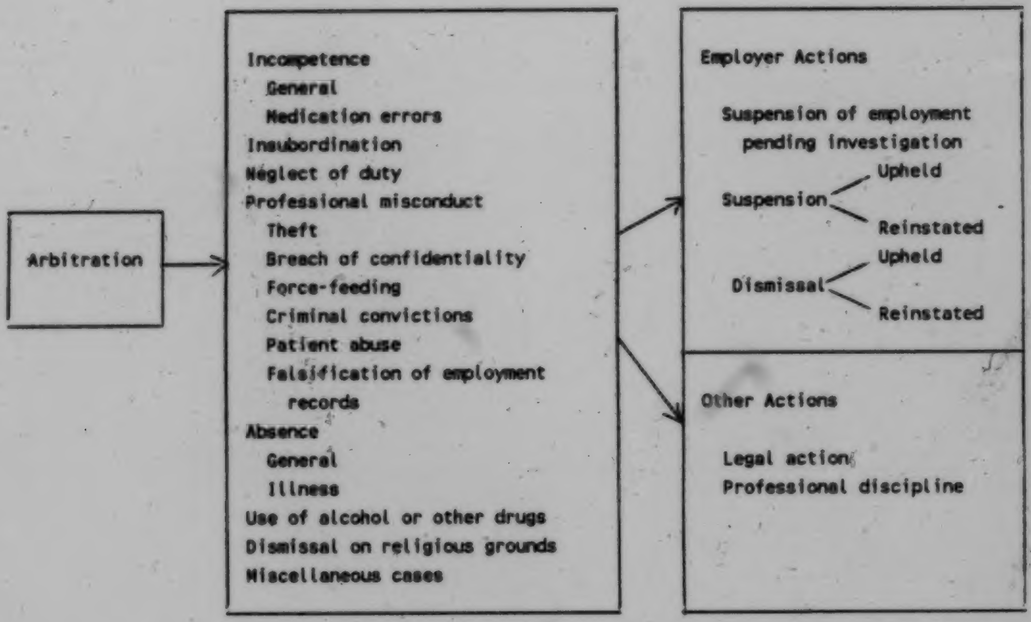
Arbitration
Incompetence
General
Medication errors
Insubordination
Neglect of duty
Professional misconduct
Theft
Breach of confidentiality
Force-feeding
Criminal convictions
Patient abuse
Falsification of employment records
Absence
General
Illness
Use of alcohol or other drugs
Dismissal on religious grounds
Miscellaneous cases
Employer Actions
Suspension of employment pending investigation
Suspension
Upheld
Reinstated
Dismissal
Upheld
Reinstated
Other Actions
Legal action
Professional discipline

Figure 5.1

A Schematic Presentation for Classifying Unacceptable Nurse Behaviours Identified in Arbitral Cases misconduct contains the following sub-categories: theft, breach of confidentiality, force-feeding of a patient, criminal conviction, patient abuse and falsification of employment records. The actions which could ensue as a result of these behaviours are: suspension of employment pending investigation; dismissal from employment; arbitration hearing as a result of a grievance; reinstatement to position as a result of the arbitration, with or without payment and benefits; a suspension being upheld; a dismissal being upheld; legal action and discipline by the professional association.

Arbitration Cases: A Selected Case Review

The purpose of this section is to review unacceptable nursing behaviours which resulted in the suspension and termination from employment of nurses in Canada. Each case was analyzed in the following manner: events leading up to the suspension or dismissal, the major arguments presented by the parties at the arbitration hearing and the judgement.

The first unacceptable nursing behaviour to be discussed is incompetence.

Incompetence

Introduction. The purpose of this section is to review unacceptable nursing behaviours where nurses were alleged to be incompetent. In this study, the arbitration cases have been divided into two major areas: (1) general incompetence and (2) incompetence as a result of medication errors. In some situations multiple reasons were cited for dismissal such as medication errors, failure to follow procedures and policies, and verbal abuse. In such circumstances, the 'culminating' incident was used in assigning the case to the specific category.

In arbitration cases relating to incompetence, boards of arbitration have generally:

> . . . affirmed management's right, in the proper circumstances, to discipline employees who fail to meet reasonable production standards, who are careless or negligent in the performance of their work, who disregard announced safety procedures, or who generally exhibit poor work habits. (Brown & Beatty, 1984, p. 411)

In assessing what is incompetence, arbitrators have used definitions outlined in collective agreements, used definitions developed by professional associations, and have heard testimony from nurses considered to be experts in the field as to what a "reasonable" professional is expected to do in a similar situation. In most circumstances, arbitrators have viewed that an employer is:

> . . . entitled to expect a higher standard of conduct, in so far as it relates to professional competence, from a professional person such as a registered nurse, than an employer in industry is entitled to expect from the average rank and file employee.
>
> The professional training and skills usually expected of a registered nurse, in so far as they relate to patient care are such that the hospital is entitled to expect that the professional integrity of the nurse would require her to carry out her duties

> efficiently and promptly. (Hospital Montfort and Ontario Nurses' Association, 1975; cited in Oshawa General Hospital and Ontario Nurses' Association, 1976, pp. 188-189)

General incompetence. In this section four cases will be described relating to alleged incompetence.

In the arbitration case involving the Vancouver General Hospital and British Columbia Nurses' Union (1984), a nurse was dismissed for a serious lack of professional judgement. The nurse had worked at the adolescent psychiatric unit from October 19, 1981 until her dismissal on February 4, 1983. During this period of employment, the nurse was involved in several incidents. The first two incidents involved swearing at patients (verbal abuse). On the first occasion she was warned that this behaviour would not be tolerated and on the second occasion she "was suspended for three days and was warned that a similar incident would result in immediate termination" (p. 5). On September 22, 1982 the nurse failed to obey a hospital policy which states that an employee is to report to the unit directly if they suspect they had been infected by a patient with pediculosis and then they are to report to the health office. For this infraction, the nurse received a memorandum of reprimand. The incident giving rise to the dismissal occurred on January 28, 1983. On that particular day, the nurse was assigned a charge nurse duty. During shift report, she was not given the status of the patients nor did she review the doctors' orders. The nurse left the unit for a short period to pick up some crafts which she had in her car. She did not notify other staff members that she was leaving the unit. On her way out to the car she met two patients and took them for a cup of coffee at a nearby restaurant. Even when one of the patients informed the nurse that she was a suicidal risk and was under constant observation (1:1), the nurse did not phone the hospital and request help. She even took time to stop at her car and retrieve the beadwork. As a result of this incident and the previous infractions the nurse was dismissed.

The arbitration board concluded that the grievor:

1. did not communicate or transfer her in-charge responsibilities to another nurse when she left the unit;

2. failed to read the doctors' orders and ascertain the status of her patients;

3. did not exercise due care and attention for the patient who was on suicidal alert;

4. did not inform other members of staff as to where she was going, or for how long she would be away;

5. failed to alert staff on the unit that she had a patient on suicidal alert requiring constant observation;

6. showed little concern for the doctors' orders when she stopped at her car;

7. showed little appreciation for her responsibilities.

The dismissal was upheld.

In the arbitration case involving Bell Telephone of Canada and Complainant (1983), a nurse employed in a health unit for eleven years was dismissed for alleged incompetence. The following reasons were cited for the dismissal: failure to keep current with new techniques and procedures; difficulty communicating with others; lack of organizational skills; and overall being viewed as insecure, high-strung and emotional. In 1981, two years before the dismissal, the nurse had been transferred to another unit with additional responsibilities. The Sector Director and the medical officer felt that the "nurse had shortcomings in her professional knowledge and the technical and administrative aspects of her position" (p. 4). The nurse in an attempt to correct these shortcomings attended various inservice training programs. During the arbitration hearing, the nurse stated that for the last ten years of her service she was rated satisfactorily. When she was transferred her work was meticulously scrutinized and she was under constant harassment from her supervisor.

The board concluded that the employer had shown a:

> . . . lack of consideration toward a faithful employee and made the error of neglecting the human factor in implementing administrative measures. . . . the conclusion must be that the grievor's dismissal was unjust. (p.17)

The nurse was awarded eleven months pay plus fringe benefits with interest.

In the arbitration case involving the Oshawa General Hospital and Ontario Nurses' Association (1976), a nurse was dismissed as a result of administering blood to the wrong patient. Following the incident, the nurse filed an incident report and ensured that the patient suffered no harmful side effects. At the arbitration hearing, the nurse testified that she had "failed to make the required check of the identification which was attached to the unit of blood with the identification which was on the patient's bracelet" (p. 185). It should be noted that following this incident the hospital revised the blood administration policies and two nurses were required to co-sign that the patient's name and hospital number on the identification bracelet matched that on the unit of blood.

Evidence given at the hearing established that the nurse had filed eight other incident reports. On four occasions the nurse had given the wrong drug to a patient. The other incidents are as follows: administered 1000cc of intravenous solution in an eight-hour period rather than a twenty-four hour period; administered the wrong amount of drug to the patient; charted a medication entry on the wrong kardex; and failed to read a medication ticket correctly thus causing a drug error.

The arbitration board concluded:

> . . . when the incident of July 12, 1975 is considered in light of eight other incidents of professional misconduct of which the grievor was guilty, we find that the hospital was correct in its decision that the grievor lacked sufficient

> professional integrity to assume the basic responsibilities which the hospital was entitled to expect of a registered nurse. Again, the grievor failed to learn from her own assessments of her negligence as set out in the various incident reports . . . and indeed failed to take heed of the progressive discipline of the one day suspension which was imposed for a related offense. . . . We therefore find that because of the hospital's duty to protect the public, it has satisfied the onus on it and has proved that it had good and just cause to discharge the grievor. (p. 189)

The dismissal was thus upheld.

In the arbitration case involving the Swan River Valley Personal Care Home and Manitoba Organization of Nurses' Association (1976), a nurse was dismissed for failure to use sterile technique in changing a supra-pubic catheter. On December 15, 1976, the nurse was requested to resign for several reasons (which were not stated in the award), the 'culminating incident' being her failure to use sterile technique. When she refused to resign she was dismissed. At the arbitration hearing, the board heard testimony from various witnesses and found that the board had failed to establish the grounds for dismissing the nurse. The nurse was reinstated with payment, seniority and benefits from the date of dismissal.

The four cases described allude to the following unacceptable nurse behaviours:

1. failure to exercise due care and attention for a patient who was on suicidal alert;
2. failure to transfer in-charge responsibilities;
3. failure to show concern for the doctors' orders;

4. failure to appreciate the responsibilities of a registered nurse;

5. failure to keep current on new techniques;

6. failure to organize duties;

7. failure to communicate with others in an appropriate manner;

8. failure to follow hospital policies and procedures in blood administration;

9. failure to use sterile technique.

In two of the four cases described, the dismissal was upheld. In one case the nurse was given eleven months' salary in lieu of reinstatement, and in the other case the nurse was reinstated with full pay. Of the above mentioned unacceptable behaviours, the employer failed to prove just cause for dismissal as a result of failure to organize duties, and failure to use sterile technique.

The next sub-category of incompetence to be described is medication errors.

Medication errors. In this section medication errors made by students and resulting in a nursing instructor being dismissed, and medication errors made by nurse practitioners are described. Of note are the discrepancies in the awards. In some situations the dismissal was upheld, in others the dismissal was reduced to a suspension and in one case the nurse was given a payment in lieu of reinstatement.

In the arbitration case involving Humber College of Applied Arts and Technology and the Ontario Public Service Employees' Union (1976), a nursing instructor was dismissed as a result of numerous medication errors being made by students under her supervision in the clinical area.

During the hearing, the board outlined the obligations of a professional nurse employed as an educator:

> . . . as a teacher of student nurses who was required to assume the professional responsibility of a registered nurse with respect to the patients while in the clinical setting, she was also required to accept her professional responsibility as a teacher of student nurses. This twofold responsibility as a nurse and teacher required the demonstration of even greater professional competence than is required of either a teacher per se or a nurse per se. Her obligations as a nurse extended not only to the patients with whom she and the students came into contact, but in addition, she was required to be so circumspect in the manner in which she exercised her professional nursing responsibilities so as to properly teach the students concerning these responsibilities. (p. 1)

The board also outlined the gravity of committing medication errors:

> . . . medication errors are always a serious matter when assessed from the patient's point of view. They became extremely alarming when students are being trained in a way which permits the commission of such errors. Training of this nature will likely tend to promote further errors in the future. (p. 2)

The board concluded that the College had reasonable cause to dismiss the grievor.

In the arbitration case involving Midale Hospital and the Saskatchewan Union of Nurses (1986), a nurse was suspended from her position and ultimately dismissed as a result of administering the drug digoxin to the wrong patient. Upon realizing the error, the nurse immediately contacted the physician and the supervisor and filed an incident report. She also apologized to the patient and checked the vital signs on an hourly basis.

At the arbitration hearing, the board heard expert testimony from Rita Garsnell, a Dalhousie graduate who completed her thesis on the effects of interruptions on the rate of medication errors. During her testimony, Garsnell reviewed the following:

1. the medication error rate of nurses can be affected by factors over which nurses have no control, such as medication work-loads;
2. studies on the medication error rate of nurses in hospitals conclude that the average error rate is 1 error in every 10 doses administered. Errors are defined as including wrong route, wrong dose, extra dose, unordered drug, wrong time, omitted dose and others;
3. interruptions in the preparation phase of medication administration affect the error rate of nurses who administer 19 to 63 doses in a four hour period. Nurses who administer less than 19 doses in a four hour period were not affected by interruptions.
4. the omission of the standard safety precautions in the administration of medications demonstrated a negative relationship to the administration error rate, meaning that a failure to follow traditional precautions did not appear to affect the medication error rates; and
5. the medication work-load of a nurse did correlate to medication error rate so that an increase in the workload corresponded with an increase in the rate of error. (Gray, 1987, pp. 3-4)

The arbitration board comments regarding Garsnell's testimony are as follows:

> The Board finds the witness's suggestion concerning the incidence of medication errors alarming. Her testimony denotes a potentially grave problem which is deserving of review by nurses, their employers, their representative bodies and their unions. Drug administration seminars should be made readily available to the nursing profession in an attempt to maintain the high standard of competence the public demands of these professionals. (p. 12)

The board considered several factors including:

1. That the nurse committed an error by misreading the medication card. The board concurred with the arbitration board in the Oshawa General Hospital and Ontario Nurses' Association (1976) in which the dismissal of a nurse was upheld because she gave the blood to the wrong patient. As stated by the arbitrator in that case:

> . . . the procedure with which we are here concerned is a simple one which any school child could be taught to perform. . . . The responsibility to perform this function is entrusted to a Registered Nurse because of her professional capacity. If a registered nurse does not possess the professional integrity which could cause her to accept this responsibility, then the hospital should not be required to employ her. (Oshawa General Hospital and Ontario Nurses' Association, 1976, p. 188)

2. That the nurse did not adhere to established procedures regarding medication administration.

3. That the board found "no merit in the union's argument that consideration should be given to the fact that the patient suffered no serious adverse affects from the medication error" (p. 15). The board concurred with the arbitration board in the case of the Oshawa General Hospital and Ontario Nurses' Association (1976):

> . . . not only did the grievor offer no excuse for her error, we are unable to imagine what possible

> excuse there could be for such a dereliction of duty in view of a very serious consequence which might have flowed from her neglect of duty. The seriousness of her default was known to her. Her dereliction of duty in these circumstances can only be described as gross negligence. (Oshawa General Hospital and Ontario Nurses' Association, 1976, p. 187)

5. The board felt that the grievor did not take responsibility for her own misconduct (p. 15).

The dismissal was upheld by the arbitration board. The board also stated, "notwithstanding this award, the grievor must be commended for her immediate action in reporting the medication error" (p. 16). The Saskatchewan Registered Nurses' Association reviewed this situation and "no disciplinary action against the nurse was taken. She has, in fact, been exonerated by her professional body" (Gray, 1987, p. 4).

In the arbitration case involving Dartmouth General Hospital and Nova Scotia Nurses' Union (1983), a nurse, who was employed on a regular part-time basis in the emergency department, was dismissed for: (1) failing to chart why the correct dosage of medication had not been given; (2) mislabelling a blood sample; and (3) failing to file incident reports in regards to these incidents.

At the arbitration hearing, the board concluded that the nurse made:

1. charting errors when she did not indicate why she had not given the full 200 mg bolux of xylocaine and when she improperly wrote 20 mg by crossing the 100 mg entry.

The board was also of the opinion that she should have filed an incident report in relation to the unusual amount of xylocaine which was ordered.

2. an error when she mislabelled the blood and did not chart the mislabelling or the fact that the blood had been drawn twice. She also failed to notify the duty doctor of the mislabelling and failed to receive authorization to draw blood a second time.

The arbitration board directed that the nurse be reinstated to her position with the following provisions:

1. the nurse be given counselling in regards to her charting errors related to xylocaine and the mislabelling of the blood specimen;

2. the nurse be given counselling in regard to her not advising the doctor of the mislabelling of blood and requesting permission to draw a second vial;

3. two incident reports be filed in regards to the xylocaine incident and the mislabelling of blood;

4. a letter of reprimand be issued by the hospital outlining the importance of incident reports;

5. the nurse be reinstated to her position with full salary and benefits. Initially, she was to be reinstated into a position in another department and gradually reintegrated into the emergency department (pp. 21-24).

In the arbitration case involving Elrose Hospital and Saskatchewan Union of Nurses (1977), a nurse was dismissed from her position as a result of an incident which occurred on January 3, 1977. On that day, the nurse was informed by a patient that the dosage for the allergy shot she was about to receive was too large. The nurse went back to the nursing station, checked the dosage with the head nurse, attended the patient, admitted her error and administered the corrected dosage of the medication. The patient's husband lodged a complaint against the nurse and she was dismissed.

The arbitration board concluded that

> in a single act of carelessness, there is agreement that such an act would have warranted only a warning or brief suspension. The hospital overreacted and imposed too severe a penalty. (p. 3)

Since the nurse reached 65 on August 1, 1977, her salary entitlement from January 21-August 1, 1977 was based on a cost-shared basis with the hospital being responsible for 2/3 and the nurse bearing 1/3 of the responsibility.

In the arbitration case involving Etobicoke General Hospital and Ontario Nurses' Association (1977), a nurse was dismissed for administering the incorrect drug to a patient. The nurse, who had been employed as a full-time regular nurse on the I.V. team for approximately two years, incorrectly administered hydrocortone, a intramuscular solution rather than hydrocortisone, an intravenous solution.

At the arbitration hearing, the board heard conflicting evidence from the grievor, the nurse-in-charge who had ordered the incorrect drug from the pharmacy and the other I.V. team nurse who co-signed that the correct drug had been given.

In assessing the penalty the board took into consideration two previous warnings the nurse had received in relation to her work, past performance appraisals, and the disciplinary action against the nurse-in-charge and the other nurse who co-signed for the drug. The board felt that "in matters of discipline, the employer must exhibit equality of treatment in its imposition of discipline" (p. 180). The nurse-in-charge received a discipline which was "somewhere between an incident report and a verbal warning" (p. 181). The other member of the I.V. team was suspended for two days. The board concluded that a three month suspension was in order for administering the incorrect solution.

In the arbitration case involving Owen Sound General Hospital and Marine Hospital and Ontario Nurses' Association (1977b), a nurse was dismissed as a result of two medication errors. On January 1976, the nurse failed to check the identiband and administered a laxative to the wrong patient. An incident report was filed and the nurse was interviewed by the Director of Nursing. In April 1976, the grievor failed to note a change in the doctor's order sheet whereby the medication was changed from demerol to talwin because of the patient's blood pressure being affected. The employer treated the "demerol" error as a culminating incident.

At the hearing, a number of mitigating circumstances were presented on behalf of the nurse:

1. the unit was extremely busy;

2. the medication area is extremely small and too crowded to permit adequate concentration;

3. the procedure involved in the administration of a "prn" medication is extremely complex;

4. the charge nurse on the night shift is responsible for the administration of a large number of medications;

5. the nurse had little experience as a charge nurse;

6. the part-time nurse handed the patient's chart to the nurse and was aware of the medication change but did not notify the charge nurse;

7. the nurse admitted in testimony that she had "probably just overlooked the change" (p. 17);

8. the nurse was not alerted to the danger of administering demerol to this particular patient because of the potential for a sudden drop in blood pressure;

9. the nurse expressed deep regret, consulted the physician and monitored the vital signs. She also filed an incident report.

The board chairman concluded that:

> . . . the grievor's reactions to her demerol error confirmed the assessment made by her colleagues and endorsed by her supervisors, that she was a truly

> conscientious nurse. I see in this a secure foundation for the hope that the grievor is someone who can be corrected and rehabilitated, she is 'redeemable.' I recognize that by calling on the hospital to give her a second chance I am imposing on it the responsibility and the financial risk that I will prove to be wrong in my assessment. . . . I hesitantly require the hospital to reinstate the grievor. (p. 20)

The award was fairly complex as a result of a pregnancy leave and discipline by the professional body. The nurse's suspension took effect on April 9, 1976. On July 1, 1976 the nurse commenced pregnancy leave. On October 6, 1976 the College of Nurses of Ontario suspended her registration for a period of six months expiring on April 8, 1977. The arbitration board claimed that no compensation could be awarded for the period July 1, 1976 to April 8, 1977. The nurse was awarded full salary and benefits from April 1, 1977 to reinstatement (p. 20).

In the arbitration case involving Extendicare Limited (St. Catherines) and Ontario Nurses' Association (1982), a nurse was dismissed as a result of unsatisfactory performance appraisal and a medication error in which the nurse had failed to chart that insulin had been given. The major deficiencies in her work performance included: inability to work constructively with other members of staff, inadequacies in filling out patient classification forms, ordering supplies and ensuring that nursing care plans were current.

The arbitration board did not concur with the "employer's assertion that the grievor was an incompetent nurse" (p. 250). The board charged that the employer had failed to utilize progressive discipline and further failed to advise the employee that she could be dismissed as a result of her actions. The board concluded that the nurse failed to understand that there was a problem in dealing with other members of the nursing team and that she was unsuited to act as a team leader or in a charge nurse capacity. Thus, the board ruled that reinstatement even for a short period of time was inappropriate. A payment of one year's salary plus a 15% fringe benefit was paid out in lieu of reinstatement.

In this section, dismissals as a result of medication errors were reviewed. The nursing behaviours which resulted in dismissal are as follows:

1. failure to ensure that student nurses were administering medications in a competent manner;
2. failure to adhere to established procedures regarding medication administration;
3. failure to take responsibility for own misconduct; and
4. failure to file incident reports relating to the error.

There were major discrepancies in the awards. One particular case is worthy of further discussion. A nurse who administered a medication to the wrong patient was dismissed from employment and the dismissal was upheld. The professional body in that province reviewed the case and took no action against the nurse (Midale Hospital and Saskatchewan Union of Nurses, 1986). In another situation the nurse administered the wrong medication to the patient and was reinstated to her position following a six month suspension of her license by the professional body (Owen Sound General Hospital and Marine Hospital and Ontario Nurses' Association, 1977b). The significance of these two cases is that the professional association in one province suspended the nurse's license for an infraction and this nurse was reinstated, yet in another province the professional association felt that no further action was warranted since the nurse took every action following the incident to ensure that the physician and supervisor were informed, monitored the vital signs, and apologized to the patient.

Gray (1987), a labour lawyer, in an article titled "Nurses, Arbitrators and Medication Errors" comments on medication errors and arbitrators' decisions:

> . . . when lawyer arbitrators are faced with similar nursing errors in the employment context, they are more apt to judge the nurse from the point of view of her legal duty of care owed to the patient than they are to judge her competence as compared to the actual standards tolerated in her own institution or within the profession as a whole. As a result, arbitrators import the fictional standards into labour arbitrations and ignore the objective facts available. Hence, the 'bad apple' theory of medication error perpetuates--if any hospitals could rid themselves of all the bad nurses. . . . The "bad apple" approach does not contribute to the correction of known institutional factors which contribute to medication errors (i.e., medication workloads, lack of unit dose med systems, lack of medication preparation areas, too complex checking mechanism,

> etc.). The approach does not force hospital management to examine in detail the problems with their medication systems, nor does it require them to examine the overall rate of medication administration. . . . It permits management to pick and choose the nurses it wishes to dispose of for having committed medication errors. Some nurses will be terminated for medication errors while others will go undisciplined for having committed similar errors. . . . The current state of arbitration on nursing issues poses more risks to the professional lives of nurses than does the professional body. This gap in reality must be overcome or the process of reviewing discipline for professional issues must change. (p. 5)

The generalizations that may be drawn from this section include:

1. nurses should adhere to the established policies and procedures for medication administration;

2. nurse educators are held accountable and responsible for medication errors committed by student nurses. A nurse educator was dismissed from employment as a result of frequent medication errors by students under her supervision;

3. arbitrators rarely consider the environmental factors which may contribute to a medication error being made, for example, medication workload, medication administration system, preparation area, the policies and procedures related to medication administration, and the standard number of medication errors.

4. the arbitrator will consider the nurses' past history in medication errors and performance appraisals when assessing whether the suspension or dismissal will be held;

5. if a nurse commits an error the following steps should be taken:

a. notify the physician and supervisor in charge;

b. monitor the vital signs if warranted and observe for side effects;

c. apologize to the patient;

d. file an incident report.

6. single acts of a medication error may warrant a "warning" or a brief suspension. Nursing administrators should utilize progressive discipline when dealing with medication errors;

7. in a case where several nurses are being disciplined for the medication error, each employee should receive the same treatment, for example, a suspension;

8. arbitrators have suggested that employers conduct medication seminars in order that nurses are familiar with the policies and procedures of medication administration.

In the cases analyzed, it was found that two cases involved suspension, two cases resulted in dismissal, two cases involved reinstatement, and one case involved payout in lieu of reinstatement. Several hospitals in various provinces are now introducing a progressive discipline system for medication errors, for example, a letter of warning for one medication error, and a suspension for three medication errors.

The next area to be explored is insubordination.

Insubordination

An arbitrator defined insubordination as a "flouting of a clear order of a person in authority" (Palmer, 1983, p. 320). Palmer (1983) outlines three components of a charge of insubordination:

> (a) there must be a clear order understood by the grievor;
> (b) that order must be given by a person in authority; and
> (c) the order must be disobeyed. (p. 320)

In this section three cases of insubordination are examined including refusal to care for a patient, refusal to carry out an examination, and refusal to work in a certain area. All three cases involved disciplinary action against the nurses.

In the arbitration case involving Mount Sinai Hospital and Ontario Nurses' Association (1978), three nurses in the Intensive Care Unit were suspended for three days for failing to:

> (1) appoint a team leader or nurse-in-charge;
> (2) accept a report and a patient from the nurse who had transferred a critically ill patient from the emergency department;
> (3) offer help in the transfer of the patient to the intensive care unit or to offer help to the medical staff for the remainder of the shift;
> (4) report fully the circumstances of the incident to the Head Nurse at morning report. (p. 243)

During the arbitration hearing, the board heard evidence from various experts in regards to professional obligations. The argument presented on behalf of the grievors was that:

1. it was never clearly communicated to them that they were to care for the patient; and

2. considering the conditions of the patients already under their care and considering the potential legal liability and professional discipline to which they might be subject if they abandoned those patients, their admitted refusal to provide nursing care was justifiable.

The board concluded that:

> (1) the grievors had no reasonable basis in fact for believing the hospital did not expect them to provide care for patient R.; and
> (2) that their "judgement" in refusing to provide that care cannot stand up to arbitral review . . . consequently on this basis alone, the hospital has made out a prima facie case of insubordination. (pp. 253-254)

The grievances were dismissed and the suspensions upheld.

In the arbitration case involving Metro-Windsor Essex County and Ontario Nurses' Association (1979), a nurse was suspended for two weeks for refusing to carry out an inspection for pediculosis captis (head lice) at a day care centre.

At the arbitration hearing, the employer testified that the nurse was suspended for refusing "an order by a person in authority and, while she had personal concerns about the work, she had an obligation to perform the assignment as directed" (p. 6). The union argued that the nurse had based her refusal on the fact that she had understood that there was a change in policy in that public health nurses were no longer required to perform "demand" inspections (p. 6).

The board felt that the nurse's unblemished record of fifteen years warranted consideration. Although the suspension was upheld, they determined that "if the grievor's record remains clear for two years from the date of the discipline, that the disciplinary notation . . . be expunged from her record" (p. 10).

In the arbitration case involving *Abbie J. Lane Memorial Hospital and Nova Scotia Nurses' Union* (1981), a nurse received a letter of discipline because she refused to float to another unit where her husband was the director. The nurse, upon commencing employment, felt that there was an understanding that she would not have to work on the unit where her husband was a director. When her supervisor ordered her to float to that unit, she refused to do so and received a letter of warning from the Director of Nursing. The letter of discipline, from the Director of Nursing~~,~~ stated "insubordination is totally unacceptable and will not be tolerated and that any future incidents of insubordination will result in disciplinary action" (p. 129).

The board concluded that the grievor had been insubordinate in that she had refused several times to obey a direct order from an immediate supervisor, ". . . her only excuse is that she thought the order conflicted with her terms of employment" (p. 132). The board also stated that since the purpose of the disciplinary letter is to provide:

> . . . a record which will be taken into account by management should there be an occasion in the future for a disciplinary decision, a record which can be referred to by the employer and the union in assessing whether on any such future occasion the proper standards of progressive discipline had been adhered to. . . . Thus in the interest of accurate information we think it just and reasonable in the circumstances to substitute a somewhat different letter. (p. 134)

A substitute letter outlining the events of May 21, 1981 was placed on the grievor's file.

In this section, suspension from employment and a disciplinary letter occurred because nurses failed to obey a direct order from their superior. Brown and Beatty (1984) outline the rule of "work now, grieve later":

> As a general proposition, employees who dispute the propriety of an employer's orders should, subject to considerations which follow, carry out those orders and only subsequently, through the grievance process, challenge their propriety. The rationale for, and the premise upon which this principle is founded, are said to lie in the employer's need to be able and his inherent right to direct and control the productive process of his operations, to ensure that they continue uninterrupted and unimpeded even when controversy may arise, and in his concomitant authority to maintain such discipline as may be required to ensure the efficient operation of the plant. (p. 343)

In this section, insubordination was reviewed. Of the three cases examined it was found that

1. three nurses received a suspension for failing to care for an intensive care patient;

2. a nurse received a suspension for failing to carry out a direct order of a supervisor to conduct an

inspection for pediculosis capitis at a day care centre; and

3. a nurse received a letter which was placed on her file, outlining the circumstances of her refusal to float to a unit where her husband was the director.

Neglect of Duty

An employee has an obligation to carry out his duties with "diligence, care, and honesty" (Palmer, 1983, p. 361). Sleeping on the job has been described as "inattention to duty" or "neglect of duty" depending on the circumstances. In this section, two arbitration cases involving nurses who were suspended or dismissed because of sleeping on the job will be discussed.

In the arbitration case involving Halifax Infirmary Hospital and Staff Nurses' Association of the Halifax Infirmary Hospital (1976), a nurse who had been employed at the hospital for approximately one year was dismissed as a result of an incident which occurred in September 1976 in the intensive care unit. On September 19, 1976 the nurse reported for work and was assigned three patients. This was her fourth consecutive twelve-hour shift. At approximately 0415 hours the nurse informed another nurse that she was going to lie down or rest. The nurse then found a blanket in one of the patient's rooms, took off her shoes, wrapped herself up in a blanket and laid down on a narrow shelf behind the monitors at the end of the intensive care unit. The night supervisor found her in that position, and awakened her to answer the telephone. At the time of the incident, the supervisor did not speak directly with the nurse but filed an assessment record on the situation. Management concluded that the circumstances warranted further action and suspended her for two days pending further investigation (pp. 6-7). A meeting between management, a union official and the nurse took place on September 16. The nurse admitted that she had gone to sleep and justified her actions as follows:

> (a) she had worked four 12 hour shifts on four consecutive days;
> (b) she had stayed up much of one day saying goodbye to her boyfriend, who was leaving for the United States;
> (c) during the last 12 hours off duty, she had an unexpected visitor whom she could not ask to leave;
> (d) consequently she had only six or eight hours sleep in a 48 hour period;
> (e) her patients were either asleep or "stable" and were not due for any routine treatment when she lay down;
> (f) she had remained in the I.C.U. and was therefore immediately available if needed. (p. 7)

The following day, management offered the nurse an opportunity to resign. The nurse refused to resign and was dismissed on September 20.

During the arbitration hearing, the Director of Nursing testified that she viewed sleeping on duty "as a matter involving gross violation of hospital regulations and professional conduct and an extremely serious neglect of duty" (p. 9). Other witnesses testified that they had occasionally nodded off to sleep or laid down in the utility room and received no reprimand. A surgeon testified that:

> . . . he considered that sleeping on the job might be consistent with good nursing care if it meant that the nurse would subsequently be able to perform more effectively; if there were other nurses to look after her patients, and if the sleeping nurse was where she could be alerted in a split second. Anyone awakened from sleep will respond maximally when an emergency occurs. He did not believe the practice of sleeping on duty was common nor did he think it should be "approved, endorsed or encouraged." (p. 16)

The arbitration board reviewed several precedent arbitration cases but concluded:

> None of these cases involves direct risk to the lives of ill and helpless persons; none as great a degree of trust; none an employee with as high a level of professional skill and training as the grievor in this case. Were it forgivable to sleep on duty in these circumstances, there would be few if any occupations where such conduct could not be condoned. (p. 19)

The board considered the following mitigating circumstances:

1. Whether or not an employee has the right to sleep during breaks for which she is not paid. In hospitals, "there is no evidence to suggest that it has ever been the custom for nurses to sleep while on breaks" (p. 18).

2. Mitigating factors such as: grievor's previous record, length of service, whether the offense is an isolated incident, provocations, lack of premeditation, economic effect of the penalty on grievor, the seriousness of the offense in terms of the employer's policy and obligations, and other relevant circumstances.

The board concluded that the offense was of such a serious magnitude as to warrant dismissal since there was:

> . . . a clear hazard to the life or health of the patients under her care. The death of a patient could in turn have led to damage suits against the grievor and the hospital and to loss of public confidence in the hospital. That no such disasters occurred reflects no credit on the grievor and does not mitigate the offense. (p. 21)

In the arbitration case involving St. Mary's Hospital, Kitchener and Ontario Nurses' Association (1983), a nurse who worked in the recovery room of the hospital was suspended for ten weeks for falling asleep. The nurse was working alone in the recovery room at the time of the incident. She was observed to be sitting in a rocking chair with a blanket around her and her eyes closed. The initial suspension of ten weeks was reduced to six weeks.

At the arbitration hearing, the board rested their decision on the question of inattention to duty. The board did not draw a conclusion as to whether the nurse had actually fallen asleep, but indicated that the evidence was consistent with the conclusion that the nurse had dozed off. The board concluded that the six week suspension was beyond the range of corrective discipline and there was no indication that the grievor's lapse was deliberate. The nurse also had no previous disciplinary record. Therefore, the suspension was reduced to one week.

The investigator, in an article titled, "Sleeping on the job: It can be hazardous to your employment," found that sleeping on the job can have serious implications not only for the nurse involved but for co-workers and supervisors (Steven, 1987, p. 3). Arbitrators in making their decisions regarding inattention to duty or neglect of duty carefully examine the circumstances surrounding the situation. If the nurse deliberately sets out to fall asleep and places a blanket around her or takes her shoes off, this has more serious consequences than merely "nodding off." One of the key points stressed by arbitrators was that management

> must consider the potential as real harm to patients as more important than even the career and welfare of one of their employees. To do otherwise . . . constitutes an unwarranted risk to life and to their future legal liabilities. (p. 24)

Professional Misconduct

In this section, various arbitration cases involving the suspension or dismissal of nurses from employment are discussed. The following types of cases will be reviewed: theft, break of confidentiality, force-feeding, criminal conviction, patient abuse, and falsification of employment records.

Theft. In the arbitration case involving St. Norbert Lodges Ltd. and St. Norbert Nurses, Manitoba Organization of Nurses' Association (1979), a nurse admitted to the Administrator, Director of Nursing and an aide that she had taken plastic bags from the nursing home. She received a dismissal notice the following day which stated, ". . . since this act destroys any confidence I have in you as an employee, I am terminating your employment" (p. 2).

The sole arbitrator heard testimony from various witnesses and concluded:

> I cannot engage in conjecture as to what might have been in the brown bag taken from the premises . . . especially when the only evidence on this point is [the grievor's] statement that the only items taken consisted of used plastic bags which were going to be thrown away by the employer, certain soft drinks she had purchased at the home, and her own sweater. . . . Weighing all the circumstances of this case, I think that what would have been sufficient is a warning letter . . . setting forth any and all areas over which the employer was not satisfied with her actions or performance. (p. 12)

The nurse was reinstated to her position with all benefits effective to date of the dismissal.

Breach of confidentiality. In the arbitration case involving Metropolitan General Hospital and Ontario Nurses' Association (1979), a nurse was dismissed when it was discovered that she had released confidential information to her husband, a private investigator, who used this information in reports to insurance companies.

The arbitration board concluded:

> . . . a staff nurse who discloses or reveals such information to an outsider in circumstances not authorized either by law or by the patient in the hospital, is guilty of misconduct and in breach of her duty to her employer for which she may be disciplined. (p. 2)

The board reduced the dismissal to an eight month suspension which coincided with a suspension invoked by the Discipline Committee of the College of Nurses.

Force feeding. In the arbitration case involving Central Park Lodge of Canada and Central Park (Brandon) Nurses, Manitoba Organization of Nurses' Association (1979), a nurse was dismissed after three years full-time employment, following complaints received about her conduct.

At the arbitration hearing, several members of staff testified that the nurse had used excessive force in administering medication or food:

> Where guests would be difficult about eating, the grievor would pinch the guest's nose with her thumb and forefinger, throw the head back roughly, and force the food or medication into the guest's mouth and throat sometimes causing the guest to gag and choke. (p. 10)

The board concluded that the nurse was "guilty of a manner of force-feeding which was at best unprofessional, and more significantly dangerous and inconsiderate" (p. 12). The board also considered the fact that although her misconduct was unprofessional for a period of two years her "coworkers did not regard the conduct as being so bad as to force them to come forward sooner to management with a complaint" (p. 15). The board therefore concluded that a three month suspension was warranted.

In the case of force feeding examined, it was found that behaviour of this type is unprofessional, and in some regards may be considered a form of patient abuse in terms of 'rough handling' of a patient. However, the conduct was not reported for a period of two years and therefore the arbitration board came to the conclusion that a three month suspension was in order. It is questionable what type of discipline would have been given had co-workers reported the incident earlier.

Criminal conviction. In the arbitration case involving Oshawa General Hospital and Ontario Nurses' Association (1981), a nurse was dismissed as a result of a criminal conviction. The grievor had been employed at the hospital from 1977 until she went on sick leave in June 1980. On September 12, 1980 the nurse and her husband were charged with possession of narcotics (marijuana) for the purpose of trafficking. On September 16, 1980, the nurse was suspended pending trial. The suspension was grieved but the board at that arbitration hearing concluded "that the suspension was justified because of her access to medication and the possible effect of her presence on patient morale" (Oshawa General Hospital and Ontario Nurses' Association, 1981). On June 16, 1981 the grievor and her husband were convicted of simple possession of marijuana and her husband was given a six month suspended sentence. Her husband was allowed to continue his employment and only lost two weeks' salary. On June 24, 1981 the Director of Nursing interviewed the grievor and advised her that her employment was terminated because of her "lack of concern . . . over the presence of marijuana in her home" (p. 202).

At the hearing, the chairman of the board outlined several reasons why the grievor's criminal conviction was unrelated to her professional competence:

> I agree with the hospital that the grievor showed a serious lapse of judgement in her handling of marijuana in her home. I find no reason to believe, however, that poor judgement in a personal situation would carry over into professional life. Good judgement in one's profession is developed through training and experience, and the objectivity which comes in their train.
>
> In my view, the best gauge of the grievor's professional judgement in future is her professional judgement in the past. There is no dispute that she has a good record over the four years of her employment at the hospital. Her evaluations are good, she has had no disciplinary warnings, and while her absenteeism is high, it is acknowledged to be blameless. . . .
>
> Indeed, this case is clearly distinguishable from other drug-related cases, cited by both counsel, in that there is no suggestion that the grievor is either a user or trafficker in drugs. Accordingly, there can be no concern that drug abuse will incapacitate her and result in nursing error. (pp. 206-207)

The board ruled that the nurse's criminal conviction for which she received a suspended sentence was unrelated to her professional competence. The nurse was reinstated to her position from the date of discharge, with back salary and benefits and without loss of seniority (p. 208).

In this particular arbitration case, it was found that the criminal conviction was not related to the professional conduct of the nurse. The nurse was neither a user or trafficker in drugs. If the nurse had been a user or trafficker of drugs the outcome would have been different since she would have been reported to the professional association and most likely have undergone a successful rehabilitation program prior to re-registration. In addition, the suspension would have been upheld because of a nurse's access to medication.

Patient abuse. In this section, two arbitration cases of alleged patient abuse will be described. In both cases, the nurses were dismissed from their positions as a result of their behaviour.

In the arbitration case involving Victoria Hospital Corporation and Victoria Hospital Nurses' Association (1975), a nurse had been dismissed following an incident on November 29, 1974 in which she "tapped" a child on the cheek.

The board heard evidence that the child involved had been a disturbance to the nursing staff and other children on the unit during the evening shift. The nurse had attempted to settle him in bed on numerous occasions to no avail. At one point, the nurse reached over and lightly "tapped" the child on the cheek using the tips of her finger. The child told the nurse "to leave him alone, and that he could do what he wanted" (p. 147). The nurse then instructed the child to put on his slippers and accompany her to the nursing station, where he sat with her while she continued to fill out her reports. The next day the mother heard that her child had been slapped and reported the incident to the physician who called for an investigation subsequently leading to the dismissal of the nurse.

During the hearing the board considered the following mitigating factors: the repeated behaviour of the child, his diagnosis, and the diagnosis of the other patients for whom the nurse was responsible. The board concluded that:

> . . . the grievor's act--gesture really--of tapping the child's cheek was precisely the right thing to do in the circumstances. That, however, may be a judgement going beyond our competence. In any event, we do not find that the grievor's act, even if it be thought ill-advised, was carried out in anger or with any improper intent. (p. 149)

The board also commented that in this case, the child's behaviour called for "the intervention of a wise parent, and it is, in a sense, that role which (among others) a professional nurse on a paediatric duty may be called on to perform" (p. 148). If the nurse had slapped the child as a form of punishment, then the board would have taken a different view of the case (p.149).

The board ordered that the nurse be reinstated to her capacity as a paediatric nurse, with full salary and benefits to date of discharge.

In the second case, a nurse slapped a patient who became aggressive and struck out at her. In the arbitration case involving Mission Memorial Hospital and Registered Nurses' Association of British Columbia (1980), a nurse was suspended and consequently dismissed for an incident which took place on September 29, 1979. Up until that time, the nurse had a seventeen year unblemished career. On that particular day, she was assigned to a paraplegic patient who was frustrated with his physical condition and often became aggressive to staff. While attempting to transfer the patient back to bed, the patient attempted to strike out at the nurse. The nurse, during the hearing, stated "I lost control and slapped him. . . . [I had] no reason to hit him--no excuse . . . it was almost a reflex thing" (p. 2). One of the other staff reported the incident to the supervisor and the nurse was requested to attend a meeting with the Director of Nursing and Nursing Care Coordinator, at which time she fully admitted her conduct. The nurse was allowed to complete her shift and she continued to care for the patient. At approximately 1700 hours she received a telephone call at home informing her that she had been suspended for three days. She also received a letter to this effect. On September 28, 1979 the grievor received a telephone call from the Nursing Care Coordinator who advised her that she had the option to resign or be dismissed. On October 1, 1979 the nurse reported for work and at 1125 hours she attended a meeting and once again was given the option of either resigning or of being dismissed immediately. The nurse was then given a discharge letter outlining that this action was a direct result of her striking a patient and failure to report the incident to her supervisor.

At the hearing, the union contended that the grievor had "multiple penalties imposed for the same cause" (p. 10). The board concluded that:

> . . . the three day suspension was designed to provide a time period in which [the grievor] could decide which route she wanted to take. In these circumstances, where no final decision as to the disciplinary penalty has been made by the employer, who may be undertaking a more comprehensive investigation of the events, seeking legal advice, or examining the employee's employment in closer detail, it is not unusual for the employer to be suspended pending a final decision or discipline. The cases do not amount to double jeopardy unless the evidence shows that the employer communicates with the employee or the union that the suspension is the final or a maximum penalty for the offense. (p. 11)

The board also concluded that:

1. the grievor slapped the patient, and although this is an "unjustified assault that cannot be tolerated . . . it is different from an unprovoked blow with intent to injure" (p. 24) which would fall into the category of criminal and civil liability;

2. the grievor admitted her conduct and willingly accepted the consequences for her actions;

3. the grievor posed no threat to the patient since she was allowed to care for him following the incident;

4. the grievor had a seventeen year record of service which was unblemished;

5. the grievor was a capable individual and a good team leader.

The board ordered that the nurse receive a 4 1/2 month suspension for her conduct. She was reinstated in the acute care unit rather than the extended care unit.

In summary, abuse of a patient is not tolerated in the employment setting. If the action is unprovoked and intentional this could lead to immediate dismissal, legal action through the courts, and professional discipline. In the two cases reviewed, one nurse was reinstated to her position for "tapping a child" on the cheek, the other nurse received a 4 1/2 month suspension from employment for slapping a patient. It should be noted that the child's behaviour of disturbing the other patients, who were critically ill, warranted the intervention of a parent to apply some form of discipline, such as mildly tapping on the cheek. If the nurse had slapped the child, a suspension or immediate dismissal could have occurred. In several other cases cited earlier, verbal abuse (swearing at a patient) and force-feeding a patient (a form of physical abuse) led to verbal warnings, letters of reprimand, suspensions and dismissal from employment. In the cases reviewed by the investigator, no cases of sexual abuse by registered nurses were found. A few cases involving nursing aides, a social worker and an administrator were investigated to determine the consequences of their actions. Verbal abuse, patient abuse, and sexual abuse are considered serious breaches of professional conduct which can lead to action being taken by one or more of the employer, the courts, and the professional body.

The next area to be examined under professional misconduct is falsification of employment records.

Falsification of employment records. In the arbitration case involving Queen in Right of Newfoundland and Newfoundland Nurses' Union (1979), a nurse was dismissed for failing to inform her present employer that she had been dismissed from her previous employment during a probationary period. The events are as follows. The nurse commenced employment at the hospital in December 1980. In April 1982, the Assistant Director of Nursing was informed that the nurse had worked at another hospital from January 7, 1980 to April 25, 1980 and "was let go before she completed her probationary period" (p. 98).

On April 26, 1982 the nurse met with the personnel officer and the Associate Director of Nursing and admitted that she had worked during this period but did not put this down on her employment application "because she did not consider it to be the type of employment history referred to. . . . She claimed that she did not feel probationary periods were important" (p. 98). On April 26, 1982 the nurse received a letter which requested that she resign or the hospital would be forced to terminate her employment. A grievance ensued.

During the hearing, the employer argued that the grievor withheld pertinent information. The union contended that:

1. the grievor was under the impression that since she had been discharged prior to the end of the probationary period it was not necessary to disclose this information;

2. for a period of seventeen months the grievor's performance was satisfactory; and

3. for a period of three weeks following the discovery of the falsification, the grievor had worked at the hospital.

The board viewed that the grievor was an educated person and could clearly understand the wording on the application form. Furthermore, the grievor knowingly withheld pertinent information about her employment history. The board's concluding remarks are worthy of note:

> . . . the board considers the conduct of the grievor to be reprehensible, but is it so damning that it disentitles her from an opportunity to practice her chosen profession? While probably we should not equate rehabilitative theories with those in the market place, nevertheless it is true that in this particular case the penalty is high. We also must not overlook the fact that there was no evidence that the untruthfulness of the grievor either prejudiced the hospital or affected the grievor's work. Also, the value of the deterrent effect on others is not overriding. Few people will be deterred from this course of conduct in the future since it is unlikely that applicants for positions at the hospital will ever have heard of the grievor or what happened to her. Taking these considerations into consideration, we feel this is a case where the board can exercise

its power to modify the penalty imposed. (p. 105)

The board concluded that the grievor's conduct warranted a one year suspension. The grievor was to be reinstated to her position as of April 25, 1983 and was to serve a one month probationary period.

In the case examined, it was found that falsification of employment records is not tolerated and led to a one year suspension.

Absenteeism

In this section, several cases involving suspension or dismissal from employment because of absenteeism, either general or related to illness, are examined. First, two cases of general absence is discussed. This is followed by a review of several cases related to illness or disability.

General. In the arbitration case involving North York General Hospital and Ontario Nurses' Association (1979), a nurse was suspended for fourteen days for exceeding the amount of sick time entitlement. The grievor's prior record included three warning letters and a suspension for four days.

During the hearing, the board based their decision regarding discipline upon the following incidents:

1. an attempt by the nurse to elevate the head of a patient who had just undergone a cervical myelogram;
2. moving a patient without due care and attention

for proper alignment;

3. rough handling of a patient;

4. alarming a patient unnecessarily about bruising caused by a subcutaneous injection of heparin;

5. inaccurate charting;

6. failing to upgrade her professional knowledge.

The board also concluded that the nurse was being harassed by the head nurse and that the incidents could have been dealt with in a more constructive manner:

> It is our view that the matter might have been handled in a more constructive manner. It is very disconcerting for an employee to have to report to work on a daily basis knowing that he or she will be subject to questioning by the supervisor. This tone of questioning takes on an inquisitional tone; the employee who is subject to this form of questioning is entitled to think it is a form of harassment. (p. 2)

The suspension was reduced to eight days. The board chairman also pointed out that it would have been more appropriate if the head nurse had worked out an educational program with the nurse, and it was expected this would occur following the hearing.

In this particular arbitration case, the board considered the employee's past performance in assessing the suspension for general absence. The arbitration board also considered the harassment from the head nurse. It seems apparent that employers should be given every opportunity by the employer to improve their skills and performance through educational programs developed conjointly by the employer and the nurse involved.

In the arbitration case involving Hotel Dieu Hospital (Windsor) and Ontario Nurses' Association (1977), a nurse was dismissed for failing to work her scheduled shifts. The events are as follows. The nurse arranged with the hospital to take her vacation from December 27-January 27, 1976 which she used for a trip.. This request was approved providing that the nurse worked her scheduled shifts on December 25 and 26. On December 21, a travel agent contacted her and informed her that if she could not leave on December 25 she would forfeit $2,600. The nurse made several attempts to change her travel arrangements to no avail. She left on December 25. Upon her return she contacted the hospital and was informed that she had been dismissed.

During the hearing, the employer argued that: (1) the grievor was denied permission to be absent; (2) a clause in the collective agreement was violated, i.e., that part-time nurses must be available to work either Christmas or New Year's in order to retain seniority, and that since the grievor was not available, seniority was lost and that this meant she was on probation and her employment could be terminated; and (3) that the grievor's actions constituted a "quitting of employment."

The board concluded that the dismissal be replaced with a three month suspension. The nurse was also assigned a new seniority date commencing December 25, 1976. The board also felt that one could not infer from the grievor's conduct that she intended to quit.

In the cases of general absence reviewed, the penalties for excessive absenteeism and failing to work shifts as scheduled led to serious penalties. The nurse who had excessive absenteeism received an initial suspension for fourteen days. This was subsequently reduced to eight days. The nurse who failed to work her shifts as scheduled received a three month suspension and a loss in seniority. In the following cases, illness was a factor which led to dismissal from employment.

Illness. In the arbitration case involving Plains Health Centre and Saskatchewan Union of Nurses (1986), a nurse was dismissed from employment and referred to the professional association as a result of recurrent sleep episodes at work. Between the period September 1982 and March 12, 1984 the grievor had approximately fourteen sleep episodes. During these episodes, the nurse was semi-conscious and upon awakening experienced uncontrollable crying and severe abdominal pain. The nurse saw approximately ten physicians for this condition, however, only speculative diagnoses were made. As a result of these sleep episodes, the hospital dismissed the nurse from employment because of their concern for patient safety.

At the time of the hearing, in June 1985, the nurse had been diagnosed, had been placed on a treatment regime, and had been virtually symptom-free.

The board concluded that the grievor be reinstated to her position, if she was able to provide the employer with written evidence of her current condition and if the employer was satisfied that her present condition was under control.

It seems apparent that employers should give employees an opportunity to correct their disability prior to imposing disciplinary action.

In the arbitration case involving Vancouver General Hospital and British Columbia Nurses' Association (1984), a nurse was dismissed for failure to account for an unauthorized absence. In this particular case, the nurse stated that she had been ill. The nurse had requested a four month leave to travel commencing October 26, 1982. This request was denied and she was notified that she was to return to work on November 25, 1982. On December 26, 1982, the nurse had failed to return to work and therefore, the hospital notified her that she had been dismissed. On January 26, 1983 the nurse returned to Canada and informed her employer that she had become ill and was unable to work or travel. She produced four medical certificates stating she was suffering from anxiety neurosis and required rest.

Upon hearing testimony, the board concluded that since nurses are professionally trained with a "high sense of responsibility and work ethic, this is all the more reason to treat failures to account for unauthorized absences as a serious breach of discipline and to deter any temptation that may arise." The board ordered that the nurse be reinstated effective the date of the hearing. In sum, the nurse lost approximately one year's salary and her seniority was decreased one year.

In the arbitration case involving Queensway General Hospital and Ontario Nurses' Association (1984), a nurse was dismissed as a result of a recurring back problem resulting in numerous absences. The hospital terminated the nurse from employment effective August 19, 1983 and also processed a long-term disability application for the nurse through their insurance company. The insurance company requested that the nurse consult an independent specialist who advised the nurse that he could correct the problem. The nurse consulted the union in regards to this matter, and the grievance challenging her discharge ensued.

The board heard a preliminary argument that the grievance was filed beyond the time limits specified in the collective agreement. The board felt that there was reasonable grounds to grant an extension because of the very special circumstances of the case.

The union argued that: (1) the employer's decision to terminate the grievor was premature; and (2) under the terms of the collective agreement, the employer cannot discharge an employee for innocent absenteeism at a time when the employee remains entitled to benefits under the long-term disability plan.

The board concluded that the hospital's decision to terminate the grievor's employment was

> premature, in the sense that it might well have deprived the grievor of substantial rights bargained for on her behalf under the collective agreement, and also was made upon grounds which cannot stand up to scrutiny. (p.21)

The board ordered the nurse to be reinstated effective to date of dismissal.

In the arbitration case involving Eastview Lodge and Manitoba Organization of Nurses (1980), a nurse was dismissed with four weeks' salary in lieu of notice, as a result of excessive absenteeism due to illness. During the period March 1978-August 28, 1978, the nurse was absent for "tennis elbow." Upon her return to work on September 13, 1978 to March 1979, the nurse continued to have several absences for union matters, personal business, and illness.

The arbitration board was of the opinion that:

> . . . an employer seeking to terminate employment must demonstrate not only a past history of unavailability to perform the contractual obligation but also a doubt as to the future capacity of the employee. (p. 24)

Since the dismissal was not based on discipline but rather the employer's determination that the continued employment of the nurse would affect operations, and this was not justified, the grievor was reinstated effective to date of dismissal.

In the arbitration case involving Queensway General Hospital and Ontario Nurses' Association (1979), a nurse was dismissed because the employee health physician felt that by working in an emergency department the nurse was under undue stress. During the period 1975-1977, the nurse injured her back on several occasions and was under Workers' Compensation. On her return to work from an injury, the nurse was referred to the employee health physician. This physician felt that by working in the emergency department, the nurse was under undue stress which affected her ability to care for patients. As a result of this assessment, the nurse was dismissed effective January 31, 1979.

The board was of the opinion that there had not been an independent and objective view by the employer to substantiate risk to the patients. The board concluded that the risk to the hospital was only a probability and there was no way to judge the likelihood of a recurrence. The nurse was thus reinstated with all entitlements.

In the arbitration case involving Scarborough General Hospital and Ontario Nurses' Association (1977), a nurse was dismissed for several illness related absences. The nurse was absent for a total of ninety-six days from October, 1962 to December 1975 and for a further seventy-two days in 1976 as a result of: hysterectomy, back surgery, viral infections and knee injury. In January 1977 the nurse was given a warning letter which stated that if she was absent on one more occasion she would be dismissed from employment. The nurse was absent for a period of four days because of a mild phlebitis. A dismissal followed.

The arbitration board felt that the hospital had not given consideration to the reasons for the absences or to the nurse's ability to return to work or ability to work on a regular basis. The board concluded:

> It is significant that as of March 7, 1977 all the medical problems of the grievor which had necessitated both short and long term absences had been overcome. . . . What must be determined, however, at the time the decision was made to terminate was whether there was on a probable basis any real and substantial concern because of what had happened in the past that the employee could not be expected to give proper and regular attendance from that point into the future. It is not sufficient to count the numbers of past absences and base that decision solely on mathematics. There must be some substantial evidence either contained in the past record or medical opinions which would lead a reasonable person to the conclusion that the employee could not be continued. (p. 2)

The board ordered that the nurse be reinstated in her former position without loss of earnings, seniority or other benefits.

In this section, cases related to general and illness related absences have been reviewed. Of note is the fact that in all the cases cited, nurses were reinstated to their former positions. The penalties imposed for general absences are extremely high. One nurse received an eight day suspension for exceeding the amount of sick time allotted in the collective agreement. The board reduced the suspension and contended that the nurse was subjected to harassment from the head nurse thereby causing stress and accompanying illness. In the second case reviewed, a nurse received a three month suspension for failing to work the shifts as scheduled because she left on a trip.

In the cases examined on absence due to illness, all nurses were reinstated to their positions by the arbitrator. It is important to note that "an employee who is ill does not require the authorization of her employer to justify her absence" (Sudbury Algoma Sanitorium and Ontario Nurses' Association, 1980, p. 1). However, nurses must notify their employers of their illness and provide medical certificates when absent beyond a set number of days (the time period is specified in the collective agreement). Failure to notify the employer of illness may lead to dismissal. A nurse who failed to notify her employer that she was ill while on an extended trip lost one year's seniority and salary as a result of her actions (Vancouver General Hospital and British Columbia Nurses' Association, 1984).

Use of Alcohol or Other Drugs

In this section, an arbitration case, which involved the dismissal of a nurse following consumption of liquor while on duty, is reviewed. In the arbitration case involving Surrey Memorial Hospital and Registered Nurses' Association of British Columbia, Labour Relations Division

(1979), a nurse was dismissed for the following events on September 30: she had arrived late for duty, she "had the odour of liquor on her breath, she was high that day, and she consumed alcohol while on duty" (p. 2).

During the arbitration hearing the nurse admitted that she had taken a vitamin B-plex (40% alcohol) prior to coming to work and that during the patients' happy-hour she had a taste of pear brandy. Other staff members on duty stated that they had seen the nurse pour two portions of whiskey, one prescribed for a patient and had taken one herself. Even though the nurse appeared "high" on that particular day, the staff members did not seem overly concerned since no one "mentioned relieving her from duty for the shift" (p. 3) although she had been assigned medication administration. The board also noted that the employer had also reinstated other employees and offered them an opportunity to rehabilitate themselves. The board concluded that a three week suspension was warranted.

"Drinking on the job or reporting for work in an impaired condition" (Palmer, 1983, p. 378) either through alcohol or drug consumption is considered valid grounds for discipline. As succinctly stated by Palmer (1983):

> The basis for this, of course, lies in the employer's right to have employees who are capable of doing their work and do not constitute a threat to themselves, their fellow employees, the employer's property or the public at large. (p. 378)

The type of discipline imposed chiefly depends on the circumstances surrounding the incident. The potential of the employee for rehabilitation is considered to be an important factor in assessing the appropriate penalty.

Dismissal on Religious Grounds

In the arbitration case involving Peterborough Civic Hospital and Ontario Nurses' Association (1981), a nurse was dismissed because she refused to perform certain aspects of her job on the basis of religious affiliation. In 1980, the nurse felt she could no longer "hang" blood although she had no problem in setting up for the transfusion or regulating the flow of blood once the transfusion had been initiated. The dismissal was based on the fact that the nurse could no longer perform an integral part of her duties.

The arbitration board heard evidence in regards to human rights and religious beliefs. The board concluded:

> (1) it is not necessary for the efficient operation of the hospital or the care and safety of patients that every nurse in the hospital be able to hang blood; and
> (2) that outside the intensive care unit and the emergency unit it would clearly not be incompatible with the safety and proper care of the patients or the efficient operation of the hospital if the grievor were to continue to be employed not withstanding her ability to hang blood. (pp. 29-31)

Therefore, the failure of the hospital to offer the nurse a position outside the intensive care unit or emergency department constituted "termination without just cause" (p. 34).

The board ordered that the nurse be reinstated without loss of seniority or benefits on the following conditions: (1) that she accept a part-time position in another area of the hospital and (2) that she notify the supervisor of any change in her beliefs. The nurse was awarded payment equal to 50% of lost wages (p. 36).

In the case reviewed, it seems apparent that nurses who cannot perform a certain task because of religious beliefs must be prepared to accept a position in another department.

Miscellaneous

Nurses have also been dismissed from their positions for questioning the sanitary conditions of the hospital and for their behaviour towards co-workers.

In the arbitration case involving Wilkie Union Hospital and Saskatchewan Union of Nurses (1972), a nurse was dismissed for questioning the sanitary conditions of the hospital's kitchenette area. The nurse had taken culture swabs from various sections of the kitchenette and forwarded them to the lab for analysis. The dismissal resulted in a six-week walkout by twelve members of the nursing staff from November 19, 1971 to January 4, 1972, at which time the hospital board and the Saskatchewan Registered Nurses' Association agreed to take the matter to arbitration.

The arbitration board concluded that the action by the nurse did not constitute proper cause for disciplinary action. The nurse was awarded full compensation for loss of wages and benefits. In addition, the arbitration board ordered that the hospital could not dismiss the nurse for one year following the award, except for "just cause."

In the arbitration case involving Thompson General Hospital and Manitoba Nurses' Association (1980), a nurse was dismissed because of her behaviour towards co-workers. On October 26, 1984 the nurse was suspended from her duties with pay while an investigation was conducted and on November 2, 1984 she was dismissed from her position effective November 23, 1984. The events followed receipt of letters by management from co-workers regarding her behaviour while on duty. A signed petition was also received from five co-workers who indicated their refusal to work with the nurse. A grievance was filed objecting to the dismissal.

The arbitration board concluded that the nurse was competent and there was no culminating incident which would warrant discipline. The nurse was reinstated with full pay and benefits from date of dismissal.

In the two cases examined it was found that (1) questioning of the hospital's sanitary conditions does not constitute grounds for dismissal; and (2) that behaviour twoards co-workers in itself is not justification for dismissal.

Summary

In this chapter an overview of dismissal for "just" cause was presented. This was followed by a general discussion of the grievance/arbitration process. General considerations in regards to arbitration cases focused on the following topics: prior record of the employee; culminating incident; organizational rules and regulations; progressive discipline with particular reference to warnings, performance appraisals and anecdotal records; probationary employees; and the concept of "resign or be dismissed." Where appropriate, specific case examples were provided.

The purpose of this chapter was to determine from arbitration cases the types of nurse behaviours which resulted in suspension or termination from employment and the arbitral consequences of these behaviours. The cases were categorized as follows: incompetence, insubordination, neglect of duty, professional misconduct, absence, use of alcohol and drug related cases, dismissal on religious grounds, and miscellaneous.

One of the major findings in this chapter was that nurses are being held increasingly responsible and accountable for their actions and the consequences of their actions are serious.

Of the cases reviewed it was found that:

1. Incompetence is grounds for suspension or

dismissal. The unacceptable behaviours identified in the cases examined were: failure to exercise due care and attention for a patient who was on suicidal alert; failure to transfer in-charge responsibilities; failure to show concern for the doctors' orders; failure to appreciate the responsibilities of a registered nurse; failure to communicate with others in an appropriate manner; and failure to follow established procedures in blood administration. Arbitrators stress the importance of employees being given an opportunity to improve their skills and performance through educational programs and the use of progressive discipline. Of prime importance is the fact that employers be informed as to exactly what it is they have done and how they can improve.

2. If a nurse commits a medication error, a letter of warning may be issued or the nurse may be suspended or dismissed for her actions. Arbitrators, in assessing the disciplinary action, consider the employee's past history in medication errors and past performance appraisals. Arbitrators rarely consider the environmental factors which may have an impact on the error occurring. It is suggested that nurses adhere to the established policies and procedures for medication administration. If a medication error occurs, the nurse should immediately notify the physician and the supervisor and file an incident report. Several hospitals are now implementing a progressive discipline system for medication errors, for

example, a suspension for a specified period for "x" number of errors. Arbitrators also suggest that employers conduct medication seminars in order that nurses are familiar with the policies and procedures of medication administration.

3. Insubordination is grounds for a letter of warning or suspension. Palmer outlines three components of a charge of insubordination:

> (a) there must be a clear order understood by the grievor;
> (b) that order must be given by a person in authority; and
> (c) the order must be disobeyed. (Palmer, 1983, p. 320)

Arbitrators suggest that nurses follow the "obey now, grieve later" concept. In other words, if a nurse receives a direct order by a supervisor, it is in the best interest of the nurse to obey the order and then file a grievance.

4. Neglect of duty is grounds for suspension or dismissal. In the cases examined it was found that a nurse was dismissed for sleeping on the job, and another nurse received a one week suspension for "nodding off." In assessing the disciplinary penalty, arbitrators consider several mitigating factors including the fact of whether the offence was premeditated or not. If a nurse deliberately sets out to fall asleep and places a blanket around her or takes her shoes off, this has more serious consequences than merely "nodding off." It was not

concluded whether sleeping on breaks for which the nurse was not paid is permissable, since no damages occurred to the patient while the nurse was sleeping. In the legal cases examined, nurses were held to be liable if the unit was not sufficiently staffed when they went on coffee breaks.

5. Professional misconduct, depending on the circumstances, is grounds for suspension or dismissal from employment. The nurse may also be referred to the professional association. In the cases examined it was found that:

a. theft of plastic bags did not warrant disciplinary action, a letter of reprimand would have been in order. The outcome would be different if theft or misappropriation of drugs from the employer were involved;

b. breach of confidentiality warrants a suspension;

c. force feeding a patient warranted a three month suspension;

d. criminal conviction, if it is not related to the professional conduct of the nurse, is not grounds for disciplinary action;

e. patient abuse is grounds for disciplinary action and the severity of the penalty depends upon whether the act was intentional or not;

f. falsification of records is grounds for immediate dismissal. In the case examined, the nurse received a one year suspension, and when reinstated to her position she was placed on a probationary period.

6. General absence and illness have resulted in nurses receiving letters of warning, suspensions and terminations from employment. Arbitrators have held the view that it is not sufficient just to count numbers as to the number of days an individual has been ill, but employers must also note the reasons for the absence. In addition, arbitrators have taken the position in the cases examined that employers:

> . . . must demonstrate not only a past history of unavailability to perform the contractual obligation but also a doubt as to the future capacity of the employee. (Eastview Lodge and Manitoba Organization of Nurses, 1980, p. 24)

Nurses have an obligation to notify their employer of an absence and provide medical certificates when absent beyond a specified number of days, as set out in the collective agreement.

7. Use of alcohol or other drugs, specifically if it occurs on the employers' premises, constitutes grounds for disciplinary action by the employer and the professional association. The type of discipline imposed depends on the circumstances surrounding the incident. The potential of the employer for rehabilitation is considered to be an important factor in assessing the appropriate disciplinary penalty.

8. In the case involving a nurse who was dismissed from employment because she could not "hang" blood based

upon her religious beliefs, the arbitration board concluded that the nurse should have been given an opportunity to work on another unit.

In the following chapter, professional discipline will be reviewed.

Chapter 6

PROFESSIONAL DISCIPLINE

The purpose of this chapter is to determine the types of nurse behaviours which resulted in disciplinary action by the professional association. This review of professional discipline appears in two major sections of the chapter. First, an overview of the legislation governing professional discipline in each province is examined. The legislation is discussed under the following sub-headings: (1) introduction; (2) complaints; (3) investigation; and (4) appeal. A summary of the legislation is presented in Table 6.1 (pp. 249-250). In addition, definitions of professional misconduct and incompetence are presented.

The second section of this chapter presents a selected review of professional discipline cases for the period 1973 through 1986.

Provincial Legislation Governing Professional Discipline

Alberta

Introduction. The Nursing Profession Act of Alberta (1983) outlines the disciplinary procedure for nurses in the province. Unskilled practise and professional misconduct are defined as:

> . . . any conduct of a registered nurse or permit holder that:
> (a) is detrimental to the best interests of the public;
> (b) contravenes this Act or the regulations;
> (c) harms the standing of the nurse profession generally; or
> (d) displays a lack of knowledge or a lack of skill or judgement in the carrying out of any duty or obligation undertaken as a registered nurse. (s. 58)

Complaints. Any person may make a complaint against a member of the profession to the Executive Director of the Association.

Investigation. The Chairman of the Professional Conduct Committee must commence a preliminary hearing thirty days following receipt of the complaint. The Chairman, on concluding a preliminary investigation, may (a) order that no further action be taken, or (b) refer the complaint to the Professional Conduct Committee (s. 63). The Professional Conduct Committee is comprised of: (a) five registered nurses appointed by the Council in accordance with the by-laws, and (b) two persons appointed by the Minister (s. 57). The Chairman may suspend the registrant pending an investigation or a decision of the Professional Conduct Committee (s. 65). The Professional Conduct Committee has powers to:

> (a) reprimand the investigated person;
> (b) suspend the registration . . . generally or from any aspect of exclusive nursing practice for a stated period;
> (c) suspend the registration until:
>   i) the person has completed a course of studies or obtained supervised practical

> experience; or
>
> ii) the Professional Conduct Committee . . . is satisfied as to the competence of the investigated person;
>
> (d) accept in place of suspension the investigated person's undertaking to limit her practice;
> (e) impose conditions on the investigated persons' entitlement to engage in practice;
> (f) direct the person to pass a particular course of study or satisfy the committee as to her competence generally or in a field of practice;
> (g) direct the person to satisfy the Professional Conduct Committee . . . that a disability or addiction can be overcome, and suspend the person until . . . the committee is so satisfied;
> (h) require the person to take counselling;
> (i) direct the person to waive, reduce or repay a fee for services rendered;
> (j) cancel the registration;
> (k) make any . . . order that it considers appropriate. (s. 76)

The Professional Conduct Committee may also order the investigated individual to pay for the costs of the hearing and/or a fine not exceeding five thousand dollars for each finding of unskilled practise (s. 77).

Appeals. An investigated person may:

> . . . by filing an originating notice with the Court of Queen's bench and serving a copy on the Executive Director, apply for an order staying the decision of the Professional Conduct Committee pending the determination of the appeal. (s. 81[2])

The Appeals Committee is comprised of three or more members of Council, one or more being appointed to the Council by the Minister. The Appeals Committee may:

> (a) make any finding or order that in its opinion ought to have been made by the Professional Conduct Committee;
> (b) quash, vary, or confirm the finding or order of the Professional Conduct Committee or substitute or make a finding of its own; and
> (c) refer the matter back to the Professional

Conduct Committee for further consideration in accordance with any direction that the Appeals Committee may make. (s. 86[4])

An investigated person may also appeal the decision of the Appeals Committee to the Court of Appeal by: (a) filing a notice with the Court of Appeal, and (b) serving the Executive Director with a copy of the appeal (s. 88).

Upon hearing the appeal, the Court of Appeal may:

(a) make any finding or order that in its opinion ought to have been made;
(b) quash, vary, or confirm the decision of the Appeals Committee;
(c) refer the matter back to the Appeals Committee for further consideration; and
(d) direct that a new trial of any mixed questions of law and fact relating to the decision of the Appeals Committee be held before the Court of Queen's Bench. (s. 91)

If a nurse has had her license suspended, a note is made on the register summarizing the reason for, and length of the suspension. Upon revocation of license, the name of the individual is removed from the register (s. 94, 95). An employer is under obligation to report any individual who has been dismissed from employment as a result of unskilled practise or unprofessional conduct (s. 97[1]).

British Columbia

Introduction. The British Columbia Nurses' (Registered) Act (1979) outlines specific regulations for discipline of members. The Registered Nurses' Association of British Columbia (RNABC) has proposed further amendments to the Act which are presently before the government (C. Kermacks, Director, Regulatory Services, personal communication, June 2, 1987). Appendix C provides a comparison of the present Act and proposed amendments.

Complaints. All complaints are received by the Director of Division Regulatory Services (C. Kermacks, Director, Regulatory Services, personal communication, February 18, 1988).

Investigation. The complaints are validated and investigated by the Investigations Coordinator or Investigations Officer who are staff members of the Association. The Investigation Report is reviewed by the Committee on Referral and Review (C. Kermacks, Director, Regulatory Services, personal communication, February 18, 1988). The Committee on Referral and Review is comprised of a Board appointed Chairman and one member of the Board of Directors, and at least three other persons, two of whom are Association members appointed by the Chairman with the approval of the Board of Directors (RNABC Constitution and Bylaws, Article IX, s. 1, cited in Registered Nurses' Association of British Columbia, 1986, p. 6).

The terms of reference for the Committee on Referral and Review are as follows:

> (1) assesses the information in the investigation summary report,
> (2) develops an opinion regarding the seriousness and significance of the conduct in question with respect to risk to the public,
> (3) recommends to the Chairman of the Discipline Committee that:
>   - no further action be taken; or
>   - there be further assessment of the situation and that the Chairman consider a discipline inquiry.
>
> (Registered Nurses' Association of British Columbia, 1986, p. 6)

The Board of Directors appoints members to the Discipline Committee for a three year period:

> . . . in addition to the Chairman and Co-Chairman, fifteen registered nurses whose education and experience represent varied areas of nursing both by area and level of responsibility and who are not directors of the Association, are chosen by the Board of Directors. (Registered Nurses' Association of British Columbia, 1986, p. 10)

The Discipline Committee acts in panels of three members (British Columbia Nurses' (Registered) Act, 1979, s. 22[2]). The Discipline Committee has power to

> . . . inquire into the conduct of a member and for that purpose each member of the committee has all the powers, protection, and privileges of a commissioner under sections 12, 15 and 16 of the Inquiry Act. (s. 22[4]).

The hearing is formal and evidence is recorded (s. 25[4]). Prior to the commencement of the hearing, the Discipline Committee may temporarily suspend the member's license until a final decision has been reached (s. 24[1]). The individual under investigation has the right to be represented by counsel and present evidence (s. 25[1]). Upon hearing the evidence, the Discipline Committee may:

(a) inform the member that he is exonerated of wrongdoing; or
(b) dismiss the citation; or
(c) determine that the member is or has been
  i) guilty of incompetence, or
  ii) guilty of conduct contrary to the ethical standards of the profession of nursing, or
  iii) guilty of a breach of this Act or the constitution or by-laws of the Association, or
  iv) guilty of fraud or misrepresentation in obtaining membership in the association; or
(d) determine that the member is or has been
  i) incapable of nursing by reason of a physical or mental condition of such a nature and extent that it is desirable in the interests of the public or the member that he no longer be permitted to practice, or
  ii) incapable of nursing by reason of habit or condition, resulting from addiction to or abuse or misuse of alcohol or drugs of such a nature and extent that it is in the interests of the public or the member that he no longer be permitted to practice; or
(e) make another disposition of the citation it considers proper. (s. 26)

The Discipline Committee has the right to:

(a) reprimand or censure the member;
(b) suspend the member for a period of time, either definite or indefinite, and on the terms and conditions the discipline committee in its discretion thinks proper;
(c) impose conditions on the continuance of the membership of the member;
(d) terminate the member's membership by striking her name from the register, or any combination of them. (s. 27[1]).

A copy of the decision and reasons must be forwarded to the individual under investigation within thirty days (s. 27[4]).

Appeal. An appeal of the decision of the Discipline Committee may be made to the Chairman of the Board of Directors by serving a notice of appeal within fifteen days (s. 28[2]). The Board of Directors upon hearing the appeal may:

(a) make an order confirming, reversing, or varying the decision of the Board of Examiners or the Discipline Committee;
(b) refer the matter back to the Board of Examiners or Discipline Committee with or without directions; or
(c) make such order as it considers proper in the circumstances. (s. 28[5])

A nurse who feels

> aggrieved or adversely affected by an order or decision of the Board of Directors may appeal to the Supreme Court at any time within thirty days after the date of refusal of the order. (s. 29[1])

It should be noted that a member may be ordered to pay all or part of the reasonable expenses incurred by the Association in the investigation (s. 30). If an individual has been suspended, a notation is made on the register of the reason and the length of suspension (s. 31). Upon termination of registration, the individual's name is removed from the register and may only be entered again following direction from the Board of Directors (s. 32[1]).

Manitoba

Introduction. The Registered Nurses Act (1980) of Manitoba specifies the procedures to be followed in the event of a complaint being received against one of its members.

Complaints. An overview of the complaints procedure is as follows. First, the complaint is directed to a

Complaints Committee. Second, the matter may be referred to an investigation chairman, and third, the complaint is reviewed by the Discipline Committee.

Investigation. The mandate of the Complaints Committee is to "receive and review complaints brought against any member in writing and where the committee considers it appropriate it shall attempt to informally resolve the matter" (s. 23[1]). The committee, appointed by the Board of Directors, is comprised of a Chairman, three members from the association, and three lay members, two of whom are appointed by the Minister, the third member is appointed by the Board (s. 22). Where a complainant does not accept the informal resolution of the Complaints Committee or where the Complaints Committee has reason to believe that a member is:

> (a) guilty of unprofessional misconduct or conduct unbecoming a member; or
> (b) has demonstrated incapability or unfitness to practice nursing or is suffering from an ailment which might if she continues to practice constitute a danger to the public, (s. 26)

then the matter is referred to an Investigation Chairman, a member of the Board of Directors, whose main responsibility is to conduct a preliminary investigation. At the discretion of the Investigation Chairman, a member's registration "may be suspended pending or following the completion of the preliminary investigation" (s. 33). Upon conclusion of the investigation, the Chairman may decide that no further action should be taken or refer the matter to the Discipline Committee.

The Discipline Committee, appointed by the Board of Directors, is comprised of four active practising members of the association and a person recommended by the Minister (s. 34[1]). The Discipline Committee

> . . . shall within thirty days from the date of direction or decision, fix a date, time and place for the holding of an inquiry which shall commence no later than sixty days from the date of the direction or decision. (s. 36[1])

All formal hearings of the Discipline Committee are held in private unless:

> . . . the person whose conduct is the subject of inquiry applies to the board for a public hearing and the board is satisfied that none of the parties to the hearing would be prejudiced by the holding of a public hearing, but where the board determines that there may be prejudice to any of the parties to the hearing it shall give reasons thereof. (s. 36[1])

If the Discipline Committee finds the member guilty of professional misconduct, conduct unbecoming to a member, unfitness to practise nursing, or to be suffering from an ailment that may constitute danger to the public, the Committee has the power to:

> (a) cause the name of the members to be erased from the register and from any other roster; or
> (b) suspend the member for a period not in excess of two years; or
> (c) reprimand the member; or
> (d) permit the member to practice upon such terms and conditions as it may deem appropriate. (s. 37[1])

Appeal. A complainant may appeal the order of the Discipline Committee to the Board of Directors by "filing a written notice of appeal at the office of the

Association . . . not later than thirty days from the date of the service of the order" (s. 38[1].

The Board of Directors within thirty days of conclusion of the appeal proceedings will:

(a) make any finding that in its opinion ought to have been made;
(b) vary the order of the Discipline Committee; or
(c) quash or confirm the finding or order of the Discipline Committee; or
(d) confirm or vary any order of the Discipline Committee as to costs or make a new order as to costs; or
(e) refer the matter back to the Discipline Committee for further consideration. (s. 41[5])

Any person whose registration has been suspended or revoked may, within thirty days, appeal the decision of the Discipline Committee or the Board to the Court of Queen's Bench (s. 42[1]).

Any member of the profession who has reason to believe that a registered nurse is suffering from a physical or mental disorder that renders her a danger to the public is obligated to report the individual to the Association. Failure to do so may be "deemed to be professional misconduct" (s. 46[1]).

New Brunswick

Introduction. The Nurses Act (1984) of New Brunswick outlines procedures to be followed in the discipline of members.

Complaints. Complaint means ". . . any report or allegation in writing and signed by the complainant regarding the conduct, actions, competence, character, fitness, health or ability of a member" (s. 27).

All complaints are referred by the Executive Director to the Complaints Committee (s. 28[2]). The Complaints Committee is charged with investigating the following alleged complaints:

> i) professional misconduct;
> ii) conduct unbecoming a member including any conduct that might adversely affect the standing or good name of the practice of nursing or the Association;
> iii) incompetence;
> iv) dishonesty;
> v) conduct demonstrating that the member is incapable or unfit to practice nursing;
> vi) any conduct in breach of the provision of this Act, the by-laws, or the rules, or
> vii) any habit rendering her unfit, incapable or unsafe to practice nursing, or
> . . . is suffering from any ailment or condition rendering her unfit, incapable or unsafe to practice nursing. (s. 28[1])

The Complaints Committee is comprised of nurses and at least one person who is not a member of the Association.

Investigation. The Complaints Committee, upon hearing the evidence, may refer the matter to the Discipline Committee or the Review Committee. Each Committee has responsibility to:

> (a) consider the complaint, hear the evidence and ascertain the fact of each case in such manner as it deems fit;
> (b) if the Committee in its absolute discretion deems it advisable, require the member in respect of whom the complaint is made to submit to physical or mental health examinations by such qualified person or persons as the Committee may designate and if the member fails

> to submit to any examination the Committee may without further notice suspend the member's registration until she does so;
>
> (c) if the Committee in its absolute discretion deems it necessary or advisable, require the member in respect of whom the complaint is made to undergo such clinical or other examinations as the Committee may designate in order to determine whether the member has adequate skill or knowledge to practice nursing and if the member fails to undergo any such examination the Committee may without further notice suspend the member's registration until she does so; and
>
> (d) if the Committee in its absolute discretion deems it necessary or advisable, require any member to produce records or documents in her possession or under her control, and if the member fails to produce such records and documents the Committee may suspend the member's registration until she does, unless the member is prohibited by law from producing such records and documents. (s. 30[7])

The individual against whom a complaint has been made is entitled to (1) a copy of the complaint, (2) copies of all documents and evidence presented to the Committee, (3) fourteen days notice of the first meeting of the Committee, (4) an opportunity to produce a written explanation or evidence (s. 29[8]), and (5) legal representation.

Following review of all the evidence presented, the Committee may:

> (a) order that the member's registration be suspended for a specific period . . .;
>
> (b) order that the member's registration or membership be suspended pending the satisfaction and completion of such conditions as may be ordered by the Committee;
>
> (c) order that the member's registration or membership be revoked and the member's name be removed from the register;
>
> (d) order that the member's practice be restricted pending compliance with stipulated conditions in which case the Committee shall notify the

member's employer of such decision;

(e) order that conditions be imposed on the member's registration or membership and so inform the member's employer;
(f) issue a reprimand;
(g) dismiss the complaint;
(h) impose such fine as the Committee considers appropriate, not exceeding $1000 . . .;
(i) order that the imposition of any penalty be suspended or postponed for such period of time and upon such terms and conditions as the Committee deems appropriate;
(j) attempt to informally resolve any complaint if the Committee deems it appropriate;
(k) make such other order as it deems just. (s. 30[8])

If a member has been convicted of a criminal offense, the Discipline Committee may order suspension of the registration pending an investigation (s. 32).

Appeal. A complainant may appeal the decision of the Complaints Committee, the Discipline Committee, or the Review Committee to the Board, within thirty days of receipt of the decision. The Board, upon hearing the evidence may:

(a) draw inferences of fact and make any finding, determination or order that in its opinion ought to have been made;
(b) vary the decision appealed from;
(c) refer the matter back to the body from whom the appeal is taken for further consideration and decision;
(d) confirm the decision appealed from; or
(e) make such order as it may deem appropriate. (s. 37)

Any party to a proceeding before the Board may appeal from the findings of the Board or any ground of appeal that involves a question of law alone to the Court.

It should be noted that if a nurse fails to report another nurse who she believes is unable to practise in a safe and competent manner, this is deemed to be professional misconduct (s. 42[1]).

Newfoundland

Introduction. The Newfoundland Registered Nurses Act (1970) outlines procedures to be followed in the discipline of members. The Council of the Association has the authority to revoke or suspend licensure (s. 23[1]).

Complaints. Upon receipt of a complaint in writing, the Council may:

> . . . by a two-thirds majority of its members personally present at a duly convened meeting of the council, revoke or suspend a license for such period as the council in its discretion decide. (s. 23[1])

Investigation. The investigation is conducted by the Council. The individual against whom a complaint has been made must be notified of the reason for the complaint and the place of hearing and be given no less than seven days notice (s. 23[4]). The individual has the right to appear before the Council or be represented by counsel (s. 23[5]). Upon completion of the hearing at which two-thirds of the Council is present, licensure may be revoked or suspended for the following reasons:

(a) dishonesty;
(b) incompetence;
(c) a habit or illness rendering the nurse unfit to care for the sick;

(d) conduct that does not conform to the standards of the profession or is unbecoming to a nurse;
(e) fraud or misrepresentation in the obtaining of a license; or
(f) default of not less than three months in payment of the annual fee fixed by the by-laws of the Association as a condition of the maintenance of membership in the association. (s. 23[2])

Appeal. The individual whose license has been revoked or suspended may appeal the decision of the Council to a judge of the Supreme Court (s. 23[6]). Seven days notice of the appeal must be given to the Council and the procedure for the appeal will be directed by the judge (s. 23[7]).

Northwest Territories

Introduction. The Nursing Profession Ordinance (1975) and the Northwest Territories Registered Nurses' Association Bylaws (1986) outline procedures to be followed in the discipline of members. A member is deemed guilty of improper conduct who:

(a) abandons a patient in danger without first ensuring that he has obtained alternative medical or nursing services;
(b) in the course of her duties knowingly provides a false or misleading oral or written statement respecting birth, death, notice of disease, state of health, vaccination, course of treatment or any other matter relating to life or health;
(c) impersonates another member;
(d) permits her name or picture to be used in connection with the advertisement of any product;
(e) irresponsibly divulges professional confidences;
(g) acts fraudulently for the purpose of procuring registration; or

(h) is convicted of a criminal offense the nature of which could affect the practice of nursing. (Nursing Profession Ordinance, 1975, s. 23)

Complaint. Upon receipt of a complaint concerning unbecoming or improper professional conduct, the Executive Director/Registrar or the President refers the matter to the Professional Conduct Committee, which may appoint an Investigating Committee, from its members, to investigate the complaint. The Investigating Committee may refer the complaint to the Professional Conduct Committee (Northwest Territories Registered Nurses' Association Bylaws, 1986, Article 13[2c]). The Professional Conduct Committee is comprised of: one lay delegate appointed by the Commissioner, one registered nurse appointed by the Board, one registered nurse appointed by the Executive Committee from the area of nursing practise being investigated, the Executive Director/Registrar and a legal advisor who act in an ex-officio capacity. Committee members are appointed for a period of two years (Northwest Territories Registered Nurses' Association Bylaws, 1986, Article 13[2a]). The responsibilities of the Professional Conduct Committee are as follows:

i) inquire into and investigate every complaint alleging improper conduct, malpractice, negligence, or incapacity on the part of a member of the Association;
ii) implement proceedings as provided for in the Ordinance and these by-laws;
iii) present and prepare a report of all hearings, inquiries and investigations and forward recommendations to the Board; and

iv) present an annual report of its activities to the Board and to the Commissioner. (*Northwest Territories Registered Nurses' Association Bylaws*, 1986, Article 13[2b])

A member whose conduct is being investigated may appear before the Professional Conduct Committee in person or be represented by legal counsel or an agent. Two weeks notice outlining the specific alleged charges and the time and date of hearing must be given to the member (*Northwest Territories Registered Nurses' Association Bylaws*, 1986, Article 13[c]v). The individual under investigation during the hearing has the right to cross-examine or produce evidence on her/his behalf. Upon completion of the formal hearing, the Professional Conduct Committee prepares a report of the hearing and the recommendations to the Board of Directors. If it has been shown that the member:

(a) has been guilty of improper conduct;
(b) has been guilty of conduct demonstrating that it is not in the public interest for her to engage in the practice of nursing;
(c) is incapable ~~of pro~~viding nursing services because of: (i) mental or physical illness; or (ii) the misuse of alcohol or drugs; or
(d) has demonstrated by one or more negligent acts or omissions that she is unfit or it is unsafe for her to be entrusted with the performance of professional responsibilities. (*Nursing Profession Ordinance*, 1975, s. 22)

the Board of Directors may reprimand, suspend registration for a period considered appropriate, or revoke the certificate of registration. Within sixty days of the hearing, the Board of Directors shall notify the member of its decision.

Appeal. A decision of the Board is final and binding and can only be overruled by a judge of the Supreme Court of the Northwest Territories (Northwest Territories Registered Nurses' Association Bylaws, 1986, Article 13[2c]xv). If the Board orders that the member's name be removed from the register, the member has the right to appeal to the judges of the Supreme Court within thirty days of the removal of her/his name (Nursing Profession Ordinance, 1975, s. 28[1]).

Nova Scotia

Introduction. The Registered Nurses Association Act (1985) outlines the disciplinary procedure. The term professional misconduct is defined as:

> . . . such conduct or acts relevant to the performance of nursing that, having regard to all the circumstances, would reasonably be regarded as disgraceful, dishonorable or unprofessional. Without limiting the generality of the foregoing, such conduct or acts shall include:
> (a) failing to maintain the standards of practice of the profession;
> (b) abusing a patient verbally or physically;
> (c) misappropriating a patient's personal property;
> (d) directly influencing a patient to change his will;
> (e) abandoning a patient;
> (f) misappropriating drugs or other property belonging to a member's employer;
> (g) failing to exercise discretion in respect of the disclosure of confidential information about a patient;
> (h) falsifying a record in respect of the observation or treatment of a patient. (Registered Nurses Association Act Regulations, 1986, p. 552)

Complaints. Any person may make a complaint against a member. Upon receipt of a complaint, the Complaints Committee will conduct an investigation into the matter or direct the Executive Director to conduct a preliminary investigation (s. 22[4]).

Investigation. The Complaints Committee upon completion of the preliminary investigation may refer the matter to the Discipline Committee or decide that no further action be taken (s. 23). The Complaints Committee may direct the Executive Director to suspend a member until an investigation has been completed (s. 25).

Where the Complaints Committee refers the matter to the Discipline Committee, an inquiry must commence 60 days from date of referral (s. 28). The Discipline Committee is comprised of no fewer five persons, the Chairman being appointed by the Board (s. 26). All hearings of the Discipline Committee are held in private unless the Discipline Committee directs otherwise (s. 31).

The Discipline Committee may find a member:

(a) guilty of professional misconduct if
  (i) the member is in contravention of this Act or the regulations,
  (ii) the member has failed to maintain the standards of practice of the profession;
(b) to be incompetent if the member has in the member's professional care of a patient, displayed lack of knowledge, skill or judgement or disregard for the welfare of a patient of a nature or to an extent that demonstrates that the member is unfit to continue in practice;
(c) incapacitated if the member is suffering from a physical or mental condition or disorder of a nature and extent that makes it desirable in the

interests of the public or the member that the member no longer be permitted to practise or that the member's practice be restricted. (s. 39)

If the Committee finds the member guilty of professional misconduct, incompetence or incapacitation, the Committee may:

(a) revoke the annual certificate of the member;
(b) suspend the annual certificate of the member;
(c) impose such restrictions on the annual certificate of the member for such a period and subject to such conditions as the Committee designates;
(d) reprimand the member and, if deemed warranted, direct that the fact of such a reprimand be recorded in the appropriate roster; or
(e) carry out any combination of the above. (s. 40)

A written report of the decision and the reasons for the decision are forwarded to the member by registered mail (s. 41).

Appeal. A member may appeal the decision of the Board by filing a notice at the office of the Association within 30 days from the date of the decision (s. 47). Upon receipt of an appeal, the Board of the Association appoints a committee of five to seven members (s. 50[1]).

The Appeal Committee upon conclusion of a hearing may:

(a) make any finding that, in its opinion, ought to have been made;
(b) vary the order of the Discipline Committee;
(c) quash or confirm the order of the Discipline Committee; or
(d) refer the matter back to the Discipline Committee for further consideration and decision. (s. 55)

Ontario

Introduction. In Ontario, three organizations represent the varied interests of registered nurses: the Registered Nurses' Association of Ontario, the College of Nurses of Ontario, and the Ontario Nurses' Association. An outline of the roles and responsibilities of each organization appears in Figure 6.1.

The College of Nurses of Ontario is a statutory body which receives its mandate from the Health Disciplines Act (1980). The primary function of the College is the protection of the public interest.

In order to practice in Ontario, a nurse must be registered with the College of Nurses and have a certificate of competence.

Complaints. Complaints made by members of the public or members of the College of Nurses are referred to the Complaints Committee. It should be noted that the Council of the College of Nurses of Ontario recently decided that "future investigations into poor nursing practice will deal only with the complaint as stated by the complainant rather than reviewing a set period of the nurse's practice" ("Council Reviews Complaints Procedure," 1984, p. 5).

Investigation. The Complaints Committee is comprised of "five persons who are members of the Council, of whom one shall be a person appointed to the Council by the

Registered Nurses' Association of Ontario

The Registered Nurses' Association of Ontario is the organization which represents the total spectrum of the nursing profession. RNAO protects the profession's interests and integrity, shaping and reflecting changes in the profession.

RNAO is there:
- when nurses gather
- when nurses seek continuing education
- when nurses speak for their patients
- when nurses seek assistance with career planning
- when nurses speak for health
- when nurses speak to government

College of Nurses

The College of Nurses is responsible to the public for ensuring that all registered nurses and registered nursing assistants in the province offer safe, competent nursing care to their patients. The College believes that providing safe care is a shared professional responsibility. In order to ensure nurses and nursing assistants achieve and maintain competence, the College has developed minimum guidelines or standards of practise. When a member allegedly fails to meet these standards, the College has a formal procedure for investigating complaints from employers, other nurses and the public, concerning a registrant's right to practise.

Ontario Nurses' Association

ONA believes that the most effective way to improve employment conditions for nurses is through collective bargaining.

ONA is convinced that collective action by nurses will result in higher professional standards and improved health care for our communities.

Collective bargaining is used to negotiate salaries, terms of employment, and hours of work. However, it is a continuous process that can help you solve day-to-day problems at work in an orderly, democratic way.

The result of this bargaining is a collective agreement. The contract will outline the conditions of employment for nurses. Every collective agreement also contains a formal grievance procedure designed to protect the rights you have negotiated and to protect you from unjust discharge or discipline.

Figure 6.1

Organizations Representing Nurses in Ontario
(From: Registered Nurses' Association of Ontario. (1986). ONA/RNAO/CNO. Toronto: Author. Reprinted by permission.)

Lieutenant Governor in Council" (s. 80[1]). The Committee may direct that the matter be referred to the Discipline Committee or the Executive Committee where appropriate (s. 81[2]).

The Discipline Committee is comprised of 10 members of Council, of whom 2 are appointed by the Lieutenant Governor in Council. In the case of professional misconduct or incompetence the Discipline Committee must:

(a) consider the allegations, hear the evidence and ascertain the facts of the case;
(b) determine whether upon the evidence and the facts so ascertained the allegations have been proved;
(c) determine whether in respect of the allegations so proved the member is guilty of professional misconduct or incompetence;
(d) determine the penalty to be imposed. (s. 83[2])

The Discipline Committee may judge a member to be incompetent if:

> . . . in its opinion he has displayed in his professional care of a patient, a lack of knowledge, skill or judgement or disregard for the welfare of the patient of a nature or to an extent that demonstrates he is unfit to continue to practice. (s. 83[4])

Where the Discipline Committee finds a member guilty of professional misconduct or incompetence it may:

(a) revoke the certificate of the member;
(b) suspend the certificate of the member for a stated period;
(c) impose such restrictions on the certificate of the member for such a period and subject to such conditions as the Committee designates;
(d) reprimand the member, and if deemed warranted, direct that the fact of such reprimand be recorded on the register;
(e) impose such fine as the Committee considers appropriate to a maximum of $5000;
(f) direct that the imposition of a penalty be

> suspended or postponed for such period and upon such terms as the Committee designates;
>
> or any combination thereof. (s. 83[5])

A Board of Inquiry may be appointed by the Executive Committee if the Director receives information leading him to believe that a member is:

> . . . suffering from a physical or mental condition or disorder of a nature and extent making it undesirable in the interests of the public or the member that he no longer be permitted to practice or that his practice be restricted. (s. 94[1]b)

The Board of Inquiry reports to the Executive Committee and if it is warranted, the Executive Committee may refer the matter to the Registration Committee and following their deliberation may:

> (a) revoke the certificate, (b) suspend the certificate for such period as the Committee considers appropriate, or (c) attach such terms and conditions to the certificate as the Committee considers appropriate. (s. 84[7]b)

Appeal. The person under investigation:

> . . . whose license has been suspended who is of the opinion that the College has not commenced proceedings expeditiously before the Discipline Committee or is not prosecuting the matter expeditiously . . . or that the Discipline Committee is not giving precedence to and hearing and determining the matter at as early a date as possible . . . may make application to the Higher Court for review. (Bill 93, 1983, s. 58a[6], [7])

Prince Edward Island

Introduction. The Nurses' Act (1973) of Prince Edward Island outlines procedures to be followed in the discipline of members.

Complaints. The Discipline Committee has ultimate authority to:

> . . . enquire into, to consider, hear, and decide subject to appeal to the Council, any charge or complaint against any member of the association for infraction of her professional duties or any act derogatory to the honour of the profession. (s. 25)

Investigation. The Discipline Committee is comprised of three members, appointed by Council, who have been in practise for at least five years (s. 23, s. 24[1]). Upon the recommendation of the Discipline Committee the Council of the Association may impose the following penalties:

(a) censure;
(b) suspension from the practice of nursing;
(c) deletion from the register and from the lists of the Association, which shall ipso facto entail dismissal from the Association;
(d) such other penalty as may be prescribed by the bylaws [October 1980] or the regulations [October 1986]. (s. 27)

Appeal. A section of the Nurses' Act reads as follows: "Every decision of the Committee on Discipline entailing suspension or dismissal is subject to Appeal to the Council" (s. 28[1]). The member under investigation has the right to appear before the Discipline Committee and at appeal before the Council. Upon hearing the Appeal, the Council must forward a decision within eight days.

Quebec

Introduction. The Professional Code (1983) specifies details and comprehensive procedures to be followed in the discipline of members.

Complaints. Every complaint lodged against a member must be forwarded to the secretary of the Committee on Discipline (s. 126). The complaint must state the nature, time and place of the offense (s. 127).

Investigation. The Discipline Committee is comprised of three members, one of whom ". . . shall be the chairman. . . . At least two other members shall be designated by the Bureau of the Corporation from among the members of the Corporation" (s. 117).

The Bureau consists of the members of the Management Committee of the Association of Nurses of the Province of Quebec and four other directors appointed by the Quebec Professions Board.

All hearings of the Discipline Committee are held in camera and proceedings are recorded (s. 142). The member under investigation has the right to "present a full and complete defense" (s. 143). The Discipline Committee has the power to:

> . . . decide to the exclusion of any court, in the first instance whether the respondent is guilty of an offense against this Code, the Act constituting the corporation of which he is a member or the regulations made under this Code or the said Act. (s. 152)

The syndic or an assistant syndic of a corporation

> . . . must refer to the Discipline Committee any final decision of a Canadian Court finding a professional guilty of an indictable offense. (s. 155)

The Discipline Committee has the power to invoke the following penalties:

(a) reprimand;
(b) temporary or permanent striking off the roll;
(c) a fine of at least two hundred dollars for each offense;
(d) the obligation to remit to any person entitled to it a sum of money the profession is holding for him;
(e) revocation of his permit;
(f) revocation of his specialist's certificate. (s. 156)

The decision of the Discipline Committee may also include a recommendation to the Bureau of the Corporation "that it require the professional to serve a period of refresher training and that it limit his right to practise certain professional activities during such period" (s. 160).

Appeal. The member may appeal the decision of the Discipline Committee by filing a petition to the office of the Provincial Court within twenty days of receipt of the decision of the Discipline Committee or within ten days if the decision has to do with striking off the register (s. 164).

The Professions Tribunal is comprised of six judges of the Provincial Court, three of whom shall hear the appeal. The tribunal to which the appeal is referred "have the powers and immunities of commissioners appointed under the Act respecting public commissions" (s. 165). Every hearing is held in camera, "unless the tribunal decides, at the request of the respondent in the first instance, that it is in the public interest that it not be held in this manner" (s. 173). The Tribunal may "confirm, alter or quash any decision submitted to it and render the decision which it considers should have been rendered in the first instance" (s. 175).

Saskatchewan

Introduction. The Saskatchewan Registered Nurses' Association Act (1978) outlines discipline procedures for registered nurses and registered nursing assistants.

Complaint. A concerned member of the public, a nursing colleague, or an employer may lodge a written complaint to the Saskatchewan Registered Nurses' Association.

Investigation. The Investigation Committee, comprised of three practising members, is charged with the following responsibilities:

(a) to receive and review written complaints or allegations brought against any member;
(b) to advise the member that a complaint has been received; ask for comments; explain the committee's role;
(c) to receive and review requests for reinstatement of registration from nurses previously disciplined by the association;
(d) to facilitate resolution of complaints or allegations or request for reinstatement by:
    (i) dismissing the complaint as being frivolous or vexatious; or
    (ii) attempting to informally resolve the matter; or
    (iii) referring the matter to the Committee on Counselling for Registered Nurses; or
    (iv) referring the matter to the Committee on Discipline for Registered Nurses; or

(v) making recommendations to Council for action. (Saskatchewan Registered Nurses' Association, Bylaws, 1986, Bylaw VIII, s. 9)

The Discipline Committee is comprised of: one elected member of the Council, four practising members, the Executive Director, one consumer representative, and the Registrar who serves as recording secretary. The Discipline Committee has authority to conduct an in-depth hearing which is held in private and make recommendations to the Council (Saskatchewan Registered Nurses' Association, Bylaws, 1986, Bylaw VIII, s. 10). The Council of the Association has ultimate authority to reprimand, suspend, and revoke licensure.

If the Council of the Registered Nurses' Association of Saskatchewan is satisfied that a registered nurse or a nursing assistant:

(a) has procured registration or certification by misrepresentation or fraud;
(b) has been guilty of professional misconduct or professional incompetence;
(c) has been convicted of any criminal offence which, in the opinion of the council, makes the person unfit to practise as a nurse or as a certified nursing assistant, as the case may be; or
(d) is incapable of practising as a nurse or as a certified nursing assistant, as the case may be; the council may order one or more of the following:
(e) that the person be reprimanded;
(f) that a restriction, limitation or condition be imposed upon the person's practice;
(g) that the registration or certification of the person be suspended for a period of time that is considered by the council to be appropriate;
(h) that the registration or certification of the person be revoked;
(i) that the person satisfactorily complete a course

of study specified by the council. (s. 25[1])

Appeal. The member may appeal the decision of the Council to the Minister. Where the Minister considers the order of the Council unjust or contrary to the public interest he may: request the Council to consider the case, appoint an arbitration board, or institute an appeal to the Court of Queen's Bench (s. 272[a]-[c]).

Yukon

The legislation in the Yukon is presently being developed.

Summary and Discussion of Legislation Governing Professional Discipline

In Table 6.1, a summary of legislation governing professional practise is presented. It should be noted that the British Columbia Registered Nurses' Act (1979) is being amended. In the information received from the provinces it was found that:

1. The provinces of Alberta, Nova Scotia, Ontario, Quebec and Saskatchewan have definitions for professional misconduct.

2. The Northwest Territories provides a definition of improper conduct although this resembles the definition of professional misconduct in other provinces.

3. The complaints procedure varies. In the provinces of Alberta, New Brunswick, Saskatchewan and the Northwest Territories complaints are directed toward the

Table 6.1

Summary of Legislation Governing Professional Practice

Province	Act	Definitions* PM	PI	IC	Complaints	Investigation	Appeal
Alberta	Nursing Profession Act, RSA, 1983, c.N-14.5	**			Executive Director	1. Chairman of Professional Conduct Committee 2. Complaints Committee 3. Professional Conduct Committee	1. Appeals Committee 2. Court of Queen's Bench
British Columbia	British Columbia Nurses (Registered) Act, RSBC, 1979, c.302 (Presently being amended)				Director, Regulatory Services	1. Investigations Coordinator or Investigations Officer 2. Referral and Review 3. Discipline Committee	1. Notice of appeal submitted to Chairman but appeal heard by Board of Directors 2. Supreme Court of B.C.
Manitoba	Registered Nurses Act, RSM, 1980, c.45				Complaints Committee	1. Complaints Committee 2. Investigation Chairman 3. Discipline Committee	1. Board of Directors 2. Court of Queen's Bench
New Brunswick	The Nurses Act, SN, 1984, c.71				Executive Director	1. Complaints Committee 2. Discipline Committee 3. Review Committee	1. Board of Directors 2. Court
Newfoundland	Newfoundland Registered Nurses Act RSN, 1970, c.268				Council	1. Council	1. Judge of the Supreme Court

*PM - professional misconduct; PI - professional incompetence; IC - improper conduct.
**Specifies definition present.

Table 6.1 (Continued)

Province	Act	Definitions*			Complaints	Investigation	Appeal
		PM	PI	IC			
Northwest Territories	Nursing Profession Ordinance, RONWT, 1975, c.6			**	Executive Director/ Registrar or the President	1. Investigating Committee 2. Professional Conduct Committee	1. Judge of the Supreme Court of the Northwest Territories
Nova Scotia	Registered Nurses' Association Act, RSNS, 1985, c.5	**	**		Complaints Committee	1. Complaints Committee and/or Executive Director 2. Discipline Committee	1. Appeal Committee
Ontario	Health Disciplines Act, RSO, 1980, c.196	**	**		Complaints Committee	1. Complaints Committee 2. Discipline Committee 3. Executive Committee (Board of Inquiry)	1. Higher Court
Prince Edward Island	Nurses Act, RSPEI, 1974, c.N-3				Discipline Committee	1. Discipline Committee	1. Council of the Association
Quebec	Professional Code, SQ, 1983, c.26 Nurses Act, SQ, 1973, c.48	**			Secretary to the Committee on Discipline	1. Discipline Committee	1. Provincial Court
Saskatchewan	Saskatchewan Registered Nurses Association Act, RSS, 1978, c.45	**	**		Executive Director/ Registrar	1. Investigation Committee 2. Discipline Committee	1. Minister

*PM - professional misconduct; PI - professional incompetence; IC - improper conduct.
**Specifies definition present.

Executive Director. In other provinces complaints may be directed to the Director of Regulatory Services or Investigations Coordinator (British Columbia), a Complaints Committee (Manitoba, Nova Scotia, and Ontario) or the Discipline Committee (Prince Edward Island).

4. The investigation procedure varies in the provinces and territories as follows: (a) in several provinces the complaint is processed by the Investigation (Complaints) Committee and then the Discipline Committee (Manitoba, New Brunswick, Nova Scotia, Ontario, Saskatchewan and the Northwest Territories). It should be noted in Ontario that the Discipline Committee deals with matters concerning incompetence and professional misconduct while the Registration Committee deals with drug and alcohol related misdemeanors; (b) in the province of Alberta, complaints are directed to the chairman of the Professional Conduct Committee, and following an investigation by an investigations officer, may be referred to the Professional Conduct Committee; (c) in Newfoundland, the investigation is carried out by the Council.

5. The appeal process varied. In some provinces the member appeals to the Appeals Committee or the Board of Directors and then to the court (Alberta, British Columbia, Manitoba, New Brunswick). In other provinces the appeal may be to a court (Ontario, Quebec) or to the Minister (Saskatchewan).

In Table 6.2, a summary of definitions for professional misconduct, professional incompetence and improper misconduct is presented. The generalizations from the definitions are as follows:

1. The provinces of Ontario, Nova Scotia, and Saskatchewan provide definitions of incompetence. In Ontario and Saskatchewan the definition is similar and alludes to a lack of knowledge, skill or judgement in regards to professional care. Ontario incorporates professional misconduct into the definition.

2. The Northwest Territories refers to a definition for improper conduct although the behaviours described are similar in nature to behaviours described in other provinces as professional misconduct; for example, patient abandonment, divulges professional confidences, and criminal offense.

3. The provinces of Alberta, Nova Scotia, Ontario, Quebec, and Saskatchewan provide a definition of professional misconduct. The behaviours cited under professional misconduct include those behaviours which are deemed to be derogatory to the profession and include (the number in brackets refers to the number of times cited):

- patient abandonment (4)
- providing false statements (1)
- impersonating another member (1)
- participating in advertising or endorsing a product (3)

Table 6.2

An Outline of Definitions of Professional Misconduct and Incompetence

Province	Professional Misconduct	Incompetence
Alberta	Unskilled practice or professional misconduct: Any conduct of a registered nurse or permit holder that, in the opinion of the Professional Conduct Committee: (a) is detrimental to the best interests of the public, (b) contravenes this Act or the regulations, (c) harms the standing of the nursing profession generally, (d) displays a lack of knowledge of or lack of skill or judgement in the carrying out of any duty or obligation undertaken as a registered nurse or permit holder, whether or not that conduct is disgraceful or dishonourable, constitutes either unskilled practice or professional misconduct or both, whatever the Professional Conduct Committee finds. (Nursing Professions Act, 1983, S.58)	
Northwest Territories	Improper conduct: (a) abandons a patient in danger without first ensuring that he has obtained alternative medical or nursing services; (b) in the course of her duties knowingly provides a false or misleading oral or written statement respecting birth, death, notice of disease, state of health, vaccination, course of treatment or any other matter relating to life or health; (c) impersonates another member; (d) permits her name or picture to be used in connection with the advertisement of any product; (e) irresponsibly divulges professional confidences; (f) engages in discriminatory practices that affect services to patients; (g) acts fraudulently for the purpose of procuring registration; or (h) is convicted of a criminal offense the nature of which could affect the practice or nursing. (Nursing Profession Ordinance, 1975, S.23)	
Nova Scotia	. . . such conduct or acts relevant to the performance of nursing that, having regard to all circumstances would reasonably be regarded as disgraceful, dishonorable, or unprofessional. Without limiting the generality of the foregoing, such conducts or acts shall include: (a) failing to maintain the standard of the profession; (b) abusing a patient verbally or physically; (c) misappropriating a patient's personal property; (d) directly influencing a patient to change his will; (e) abandoning a patient;	. . . displays lack of knowledge, skill or disregard for the welfare of a patient or a nature or to an extent that demonstrates that the member is unfit to continue in practice (Registered Nurses Association Act, 1985, s. 39)

Table 6.2 (Continued)

Province	Professional Misconduct	Incompetence
Nova Scotia (continued)	(f) misappropriating drugs or other property belonging to a member's employer; (g) failing to exercise discretion in respect of the disclosure of confidential information about a patient. (h) falsifying a record in respect of the observation or treatment of a patient. (Registered Nurses Association Act, Regulations, 1986, p. 552)	
Ontario	. . . failure to maintain the standards of practice of the profession: (a) the contravention of Part IV, Health Disciplines Act (1980, c. 196); (b) abusing a patient verbally or physically while employed as a registered nursing assistant; (c) misappropriating a patient's personal property; (d) having a conflict of interest; (e) directly influencing a patient to change his will; (f) abandoning a patient; (g) misappropriating drugs or other property belonging to a member's employer; (h) participating in advertising or endorsing a product; (i) failure to inform the member's employer of the member's inability to accept specific responsibility in areas where special training is required or where the member does not feel competent to function without supervision; (j) failure to report the incompetence of colleagues whose actions endanger the safety of the patient; (k) failure to exercise discretion in respect of the disclosure of confidential information about a patient; (l) falsifying a record in respect of the observation or treatment of a patient; and (m) conduct or an act relevant to the performance of nursing services that, having regard to all circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional. (Regulations made under the The Health Disciplines Act, 1980, s. 21)	(a) guilty of an offense relevant to his suitability to practise; (b) in contravention of 75(1)--no person shall hold himself out as competent to practise unless he is a holder of an appropriate certificate; (c) he has been guilty in the opinion of the Discipline Committee of professional misconduct. (Health Disciplines Act, RSPO, 1980, c. 196, s. 83(5))

Table 6.2 (Continued)

Province	Professional Misconduct	Incompetence
Quebec	Classified as derogatory to the dignity of the profession: (a) to consult, collaborate or agree with, in the treatment of a client, a person who does not have the appropriate scientific knowledge in the field in which he practises; (b) to practise his profession while under the influence of alcoholic beverages, drugs, hallucinogens, narcotic or anaesthetic preparations or any other substance which may cause intoxication, a diminuation or disorder of the faculties or unconsciousness; (c) to appropriate drugs, narcotic or anaesthetic preparations, supplies of any kind or any other property belonging to his employer or a client; (d) the fact of inducing someone in pressing terms to make use of his professional services; (e) to permit any person who is not entered on the roll of the Order to practise the profession; (f) to voluntarily abandon a client who requires supervision or to refuse to provide services without sufficient reason and without ensuring competent relief in cases where he may reasonably ensure such relief; (g) to perform an act or be of a comportment contrary to that which is generally admissible to the practice of the profession; (h) to enter false items in a client's record or to insert notes under another person's signature; (i) to alter in the client's record notes already entered or to replace any part thereof with intent to falsify them; (j) to participate or to collaborate in the advertising of medications, panaceas, pharmaceutical products and prostheses of all kinds; (k) to advertise a product anonymously, under his name or a firm name; (l) to communicate with the plaintiff whenever he is informed of an inquiry into his professional conduct or competence or whenever a complaint has been served against him. (Code of Ethics of Nurses, 1983, 4.01.01)	
Saskatchewan	(a) abused a patient verbally or physically; (b) misappropriated a patient's personal property; (c) a conflict of interest whereby the member inappropriately uses professional status for personal gain; (d) influenced a patient to change his last will and testament;	A registered nurse or a certified nursing assistant may be found guilty of professional incompetence if in the professional care of a patient the person has displayed a lack of knowledge, skill or judgement or a disregard for the welfare of a patient of a nature or to an

Table 6.2 (Continued)

Province	Professional Misconduct	Incompetence
Saskatchewan (continued)	(e) wrongfully abandoned a patient; (f) misappropriated drugs or other property belonging to a member's employer; (g) failed to inform a member's employer of the nurse's/nursing assistant's inability to accept specific responsibility in areas where special training is required or while the member does not feel competent to function without supervision; (h) failed to report the incompetencies of colleagues whose actions endanger the safety of the patient; (i) failed to exercise discretion in respect of the disclosure of confidential information about the patient; (j) falsified a record in respect of the observation, rehabilitation, or treatment of a patient; (k) failed to comply with the code of ethics of the association; (l) failed without reasonable cause to respond to enquiries from the association regarding alleged professional misconduct or professional incompetence; (m) conspired to do any misconduct or counselled a person to do any misconduct. (Saskatchewan Registered Nurses Association Bylaws, 1985, XV, s. 1)	extent that demonstrates that the person: (a) is unfit to continue in practice; or (b) is unfit to provide one or more services ordinarily provided as part of the practice of a registered nurse or certified nursing assistant. (Saskatchewan Registered Nurses' Association Bylaws, 1985, XV, s. 2.

- failure to exercise discretion in respect of disclosure of confidential information (4)
- fraud (2)
- criminal conviction which could affect practise (1)
- failure to maintain the standard of the profession (3)
- physical or verbal abuse of a patient (3)
- missappropriating a patient's personal property (3)
- directly influencing a patient to change his will (3)
- falsifying a record (4)
- conflict of interest (1)
- misappropriating drugs (2)
- failure to inform the member's employer of the member's inability to accept specific responsibility in areas where special training is required or where the member does not feel competent to function without supervision (2)
- failure to report the incompetence of colleagues whose actions endanger the safety of the patient (2)
- to consult, collaborate, or agree with, in the treatment of a client, a person who does not have the appropriate scientific knowledge in the field in which he practises (2)

- practising while under the influence of alcoholic beverages, drugs, hallucinogens, narcotic or anaesthetic preparations or any other substance which may cause intoxication, a diminuation, or disorder of the faculties or unconsciousness (1)
- inducing someone to make use of the professional's services (1)
- to perform an act which is contrary to the practise of the profession (2)
- to communicate with the plaintiff whenever he is informed of an inquiry into his professional conduct (1)
- a conflict of interest whereby the member inappropriately uses professional status for personal gain (1)
- failure to comply with the code of ethics of the association (1)
- failure to respond to inquiries from the association regarding alleged professional misconduct or professional incompetence (1)
- conspiring to do any misconduct or counselling a member to do any misconduct (1).

One of the concerns voiced by nurses at the "grass roots" is the composition of the Discipline Committee. Practitioners question how a committee can assess their competency if they have not worked in a particular area, e.g., intensive care setting. Some provinces are taking remedial action in this area and developing a "revolving" committee structure whereby specialists from particular nursing areas would sit on the committee when a nurse's competency is being assessed in that specialty area. Other professional associations may wish to consider this avenue.

In this section, an overview of the legislation governing professional discipline was presented in order to provide background information for the reader. In addition, definitions of professional misconduct, incompetence and improper conduct were reviewed.

The main focus of this chapter is to determine the types of nurse behaviours which resulted in disciplinary action by the professional association. In Figure 6.2 a schematic presentation for classifying unacceptable nursing behaviours is presented. The classification scheme for types of nurse behaviours include: incompetence, professional misconduct, professional misconduct and incompetence, alcohol related, drug related, interpersonal problems and a miscellaneous category. Depending upon the circumstances of the case, the professional actions which could occur as a result of unacceptable nursing behaviour are: revocation of license, suspension of license, reprimand, dismissal of complaint, suspension of penalty, restriction on practice, counselling, and a miscellaneous category. Other actions

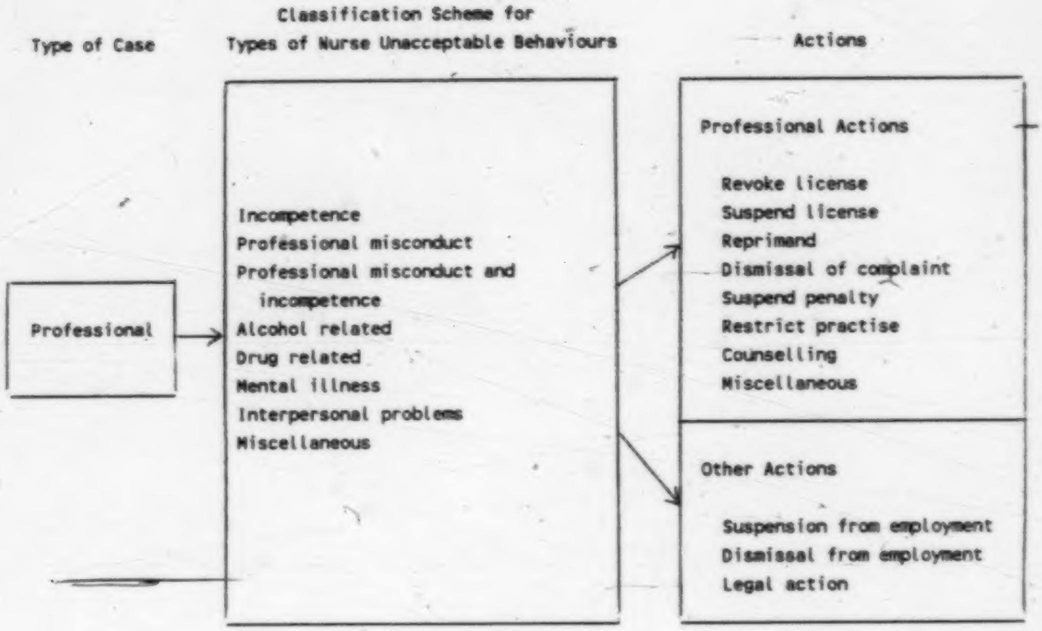
Type of Case
Classification Scheme for
Types of Nurse Unacceptable Behaviours
Actions
Professional
Incompetence
Professional misconduct
Professional misconduct and incompetence
Alcohol related
Drug related
Mental illness
Interpersonal problems
Miscellaneous
Professional Actions
Revoke license
Suspend license
Reprimand
Dismissal of complaint
Suspend penalty
Restrict practise
Counselling
Miscellaneous
Other Actions
Suspension from employment
Dismissal from employment
Legal action

Figure 6.2

A Schematic Presentation for Classifying Unacceptable Nurse Behaviours
Identified in Professional Discipline Cases

which could occur at the same time are: suspension from employment, dismissal from employment, and legal action including a civil or criminal lawsuit.

One of the major limitations of this study, identified in Chapter 1, was that professional discipline cases are heard in private by members of a complaints committee, investigation committee, discipline committee or the executive of the professional association. The information is of a confidential nature and therefore is not easily accessible to the public. The researcher contacted each professional association and requested information related to professional discipline. Information was not received from New Brunswick, Saskatchewan and the Yukon. Saskatchewan reported that statistical information was not available. Several provinces also forwarded individual cases to the investigator with the provision that anonymity would be assured.

The Province of Quebec forwarded professional discipline cases in French and the Faculté Saint-Jean at the University of Alberta provided translation services. Where clarification was required, telephone calls were made to the association.

Discipline Cases in Various Provinces

In this section information related to professional discipline is reviewed for each provincial jurisdiction.

Alberta

The Alberta Association of Registered Nurses (C. Fleming, Investigations Officer, personal communication, June 18, 1987) reported that during the period 1973-1986, 159 complaints were received; of those, 64 complaints were dismissed. In Table 6.3 a summary of professional discipline cases is presented. A breakdown of the cases is as follows:

Incompetence	3
Professional misconduct	3
Alcohol related	6
Drug related	37
Mental illness	11
Interpersonal problems	3
Miscellaneous	15

The miscellaneous category included such behaviours as poor judgement, carelessness, abuse of sick time, dishonesty, illness and alcohol and drug abuse. The disciplinary actions associated with unacceptable nursing behaviours during the period 1973-1986 are revocation of license (10), suspension of license (55), reprimand (11), and referral for counselling (2).

Table 6.3

A Summary of Professional Discipline Cases in Alberta, 1973-1986

Reason	73	74	75	76	77	78	79	80	81	82	83	84	85	86	Total
Number of complaints	12	3	5	10	26	6	8	8	10	11	12	18	11	19	159
Dismissal of complaints	1	-	2	2	21	1	2	4	4	7	5	4	4	7	64
Disciplinary action															
1. Incompetence															
Revoke license		1													1
Suspend license				1							1				2
Reprimand															
Dismiss															
Suspend penalty															
Restriction															
Counselling															
Other															
Sub-total		1		1							1				3
2. Professional misconduct															
Revoke license														1	1
Suspend license	2														2
Reprimand															
Dismiss															
Suspend penalty															
Restriction															
Counselling															
Other															
Sub-total	2													1	3
3. Professional misconduct and incompetence															
Revoke license															
Suspend license															
Reprimand															
Dismiss															
Suspend penalty															
Restriction															
Counselling															
Other															
Sub-total															
4. Alcohol abuse															
Revoke license															
Suspend license			1				1	1	1			1			5
Reprimand							1								1
Dismiss															
Suspend penalty															
Restriction															
Counselling															
Other															
Sub-total			1				2	1	1			1			6
5. Drug abuse															
Revoke license							1		1	2	1	1		1	7
Suspend license	1		1	2		4	1	2	2	2	1	6	4	3	29
Reprimand									1						1
Dismiss															
Suspend penalty															
Restriction															
Counselling															
Other															
Sub-total	1		1	2		4	2	3	3	4	2	7	4	4	37

Table 6.3 (Continued)

Reason	73	74	75	76	77	78	79	80	81	82	83	84	85	86	Total
6. Mental illness															
Revoke license															
Suspend license	5		1	1							1	2		1	11
Reprimand															
Dismiss															
Suspend penalty															
Restriction															
Counselling															
Other															
Sub-total	5		1	1							1	2		1	11
7. Interpersonal problems															
Revoke license															
Suspend license	1														1
Reprimand															
Dismiss															
Suspend penalty															
Restriction															
Counselling	2														2
Other															
Sub-total	3														3
8. Miscellaneous															
Poor judgement				2R	2R	1R					1S				5R;1S
Carelessness							2R								2R
Abuse of sick time												1S			1S
Dishonesty										1R			1R		2R
Unfit to practise															
Illness				2S											2S
Alcohol & drugs									1S		1Re				1S;1Re
Reinstatement					3	1	1	3	1	3	3	4	4		23
Total	11	1	3	8	2	5	6	4	6	4	7	11	4	6	78

Code: R - Reprimand
S - Suspend license
Re - Revocation of license

British Columbia

The Registered Nurses' Association of British Columbia (C. Kermacks, personal communication, June 2, 1987) reported that formal discipline hearings commenced in 1975, therefore limited data prior to that date exist. In 1973, two cases involving mental illness and in the following year two cases involving drug abuse were reviewed by the Association. The Association also provided information related to several significant changes in the British Columbia Nurses (Registered) Act which is presently under amendment (Appendix C). The functions of the Committee on Referral and Review changed in 1985. Kermacks (1987), Director, Regulatory Services, Registration and Manpower, outlines these changes:

> Prior to 1985, the committee had three options. It could make recommendations to the nurse and if the nurse followed the prescribed actions the matter did not progress to discipline unless the problem persisted. Now the committee does not have this option and can make only one or two recommendations to the discipline committee chairman, either to take no further action or to consider an inquiry. The discipline committee chairman is the only person under the Nurses (Registered) Act who can order a discipline inquiry. (p. 2)

In Table 6.4, a summary of professional discipline findings and actions is presented. A breakdown of the cases is as follows:

Incompetence	26
Unethical conduct	43
Incapable of nursing	16
Incompetence and unethical conduct	17

Table 6.4

Discipline Findings and Actions: Registered Nurses' Association of British Columbia
1975-1987

Findings/Actions	75-76	77	78	79	80	81	82	83	84	85	86	87	Total
Exonerate	1				1								2
Dismiss											2		2
Incompetence													26
Reprimand/Censure		1				2							3
Conditions of Membership					1						1		2
Suspend - with Terms and Conditions		1-D			1								2
Suspend - Indefinite*		2	1-D 2	1									6
Terminate/Revoke	2		3	1		1-D		1		1		⓵-D	10
Suspend Decision with Conditions				1 →		T			1-D 1 →		T		3
Unethical Conduct													43
Reprimand/Censure		1	1-Ab 3	3	2					1		2	13
Reprimand & Conditions					1-Ab								1
Reprimand & Suspend											1		1
Suspend, then Conditions				1-Ab							1-D&A 1-A		3
Suspend - with Terms & Conditions	1-D				1-D								2
Suspend - Indefinite*	1-Ab	1											2
Terminate/Revoke	2-D 3-D	2-D	1-D	1-D		1-D					1-D		11
Resignation with Prejudice										2-A 1-Ab 3-D		1-D 1-A	8
No Action		2											2

Legend: Ab: Abuse; A: Alcohol-related; D: Drug-related; M: Mental illness; P: Physical disability; T: Terminate.

*Indefinite suspension approximately equivalent to termination of membership.

Notes: In situations where one decision made and later another decision taken, this is indicated by a line with an arrow to the second decision; e.g., suspended decision with conditions followed later by termination of membership. The second decision not counted as separate decision. Numbers circled indicate individuals where discipline actions have occurred twice, i.e., after first action individual has been reinstated, then another complaint received and inquiry held.

Source: Registered Nurses' Association of British Columbia, Personal communication, March 13, 1988.

Table 6.4 (Continued)

Findings/Actions	75	76	77	78	79	80	81	82	83	84	85	86	87	Total
Incapable of Nursing														16
Suspend, then Conditions												1-A→T	1-M	2
Suspend - with Terms & Conditions							1-M							1
Suspend - Indefinite*	1-M		2-M	1-M 1-D&A	1-D									6
Terminate/Revoke				1-D				1-A	1-M	1-M				4
Board Cancellation	1-M&P	1-D	1-P											3
Incompetence & Unethical Conduct														17
Reprimand/Censure							1							1
Reprimand & Conditions						1								1
Suspend with Terms & Conditions				1						1-D		1		3
Terminate/Revoke		2	1-Ab	1					1-D	1-D (1-A)	1-M	1	2	11
Suspend Decision with Conditions							1 →			T				1
Unethical & Incapable of Nursing														19
Suspend, then Conditions												1-D	1-D&A 2-D	4
Suspend - with Terms & Conditions											3-D (1-D&A)		1-D	5
Suspend - Indefinite*	1-A 1-M	1-A	1-D											4
Terminate/Revoke		1-D&A	1-D							1-D&A		2-D (1-D)		6

Legend: Ab: Abuse; A: Alcohol-related; D: Drug-related; M: Mental illness; P: Physical disability; T: Terminate.

*Indefinite suspension approximately equivalent to termination of membership.

Notes: In situations where one decision made and later another decision taken, this is indicated by a line with an arrow to the second decision; e.g., suspended decision with conditions followed later by termination of membership. The second decision not counted as separate decision. Numbers circled indicate individuals where discipline actions have occurred twice, i.e., after first action individual has been reinstated, then another complaint received and inquiry held.

Source: Registered Nurses' Association of British Columbia, Personal communication, March 13, 1988.

Table 6.4 (Continued)

Findings/Actions	75	76	77	78	79	80	81	82	83	84	85	86	87	Total
Incompetence & Incapable of Nursing														3
Terminate/Revoke							1-P&M						1-M	2
Resignation with Prejudice												1-A		1
Incompetence & Unethical & Incapable														3
Terminate/Revoke											1-M		1-M	2
Board Cancellation	1-D													1
Inquiry Postponed Indefinitely									1	1			2	4
TOTAL	7	13	16	16	9	8	8	1	4	8	14	15	16	135
APPEALS														
Board of Directors			1	4		1	1	2			2	1		12
Supreme Court of B.C.			1		1			1	1				1	5

Legend: Ab: Abuse; A: Alcohol-related; D: Drug-related; M: Mental illness; P: Physical disability; T: Terminate.

*Indefinite suspension approximately equivalent to termination of membership.

Notes: In situations where one decision made and later another decision taken, this is indicated by a line with an arrow to the second decision; e.g., suspended decision with conditions followed later by termination of membership. The second decision not counted as separate decision. Numbers circled indicate individuals where discipline actions have occurred twice, i.e., after first action individual has been reinstated, then another complaint received and inquiry held.

Source: Registered Nurses' Association of British Columbia, Personal communication, March 13, 1988.

Unethical and incapable of nursing	19
Incompetence and incapable of nursing	3
Incompetence, unethical and incapable	3
Inquiry postponed indefinitely	4

Of particular note is the landmark case on incompetence described below. The case is considered to be precedent setting since it was the first legal case involving the incompetence of a nurse.

Case 1. In Mason v. Registered Nurses' Association of British Columbia (1979), a nurse appealed the decision of the discipline committee to suspend her license for an indefinite period as a result of incompetence. The Supreme Court of British Columbia upheld the finding of the tribunal. The nature of the charges was as follows:

1. Administered penicillin G to a patient who was allergic to the medication. When questioned why, the nurse allegedly stated, "A lot of people think they are allergic to penicillin when they're really not" (p. 7).

2. Administered 250 mgm intravenously by Volu-Trole instead of into a 500 cc bag of intravenous solution.

3. Recorded that the same blood transfusion was given on two occasions (error in recording transfusion number).

4. Failed to perform a nursing assessment, failed to complete the admission note, and failed to assess the patient at regular intervals for a maternity patient who

had a history of miscarriages.

5. Administered 60 cc of castor oil as preparation for an oral cholecystogram, when the preparation was actually for an intravenous cholangiogram and by this error delayed the patient in having tests.

6. Charted that a patient had a fat-free diet three quarters of an hour prior to the supper trays being delivered to the unit.

During the appeal process, the Honourable Mr. Justice Anderson stated:

> As this is the first case dealing with allegations of incompetence I requested counsel to provide me with such authorities as could be found relating to the meaning of the word "incompetence." . . . There is a dearth of authority in Canada as to the meaning of the word as it applies to disciplinary proceedings against professional persons. There are, however, a number of American authorities. (p. 13)

The following principles were discerned from the American authorities:

1. The particular definition placed upon the word "incompetency" should be molded by the object of the enactment in which the word appears.
2. All the definitions of "incompetency" focus on the lack of ability, capacity, or fitness for a particular purpose.
3. The want of capacity, ability or fitness may arise from a lack of physical or mental attributes. However, a person not lacking in physical or mental attributes may nonetheless be incompetent by reason of a deficiency of disposition to use his or her abilities and experience properly.
4. Negligence and incompetence are not interchangeable terms. A competent nurse may sometimes be negligent without being incompetent. However, habitual negligence may amount to incompetence.
5. A single act of negligence unaccompanied by circumstances tended to show incompetence will

> not of itself amount to incompetence.
> From my study of the above authorities I have concluded that for the purposes of this statute the word incompetent falls within the definition set out in Crotwell v. Cowan. Thus, while a nurse may be fully qualified and able, if her conduct demonstrates a pattern of carelessness and she is of a disposition or temperament whereby she fails to respond to advice as to her shortcomings, she may be found guilty of incompetence. (pp. 23-24)

Manitoba

The Manitoba Association of Registered Nurses (S. Wiebe, Executive Director, personal communication, June 8, 1987) reported that during the period 1973-1980, 60 investigations were conducted and 13 hearings held. In Table 6.5, a summary of professional discipline cases is presented. A breakdown of the cases is as follows:

Incompetence	4
Professional misconduct	3
Drug related	5
Unfit to practise	1

New Brunswick

Information related to professional discipline was not received.

Newfoundland

The Association of Registered Nurses of Newfoundland (V. Ruelokke, Executive Secretary, personal communication, June 24, 1987) reported that during the period 1973-1986 a total of 17 disciplinary hearings were held (Table 6.6). A breakdown is as follows:

Table 6.5

A Summary of Professional Discipline Cases in Manitoba, 1973-1986

Reason	73	74	75	76	77	78	79	80	81	82	83	84	85	86	Total
Number of complaints															
Dismissal of complaints															
Disciplinary action															
1. Incompetence															
Revoke license															
Suspend license															
Reprimand															
Dismiss															
Suspend penalty															
Restriction															
Counselling															
Other															
Sub-total			1							1		2			4
2. Professional misconduct															
Revoke license															
Suspend license															
Reprimand															
Dismiss															
Suspend penalty															
Restriction															
Counselling															
Other															
Sub-total										1		2			3
3. Professional misconduct and incompetence															
Revoke license															
Suspend license															
Reprimand															
Dismiss															
Suspend penalty															
Restriction															
Counselling															
Other															
Sub-total															
4. Alcohol abuse															
Revoke license															
Suspend license															
Reprimand															
Dismiss															
Suspend penalty															
Restriction															
Counselling															
Other															
Sub-total															
5. Drug abuse															
Revoke license															
Suspend license															
Reprimand															
Dismiss															
Suspend penalty															
Restriction															
Counselling															
Other															
Sub-total							1		1	1		1		1	5

Table 6.5 (Continued)

Reason	73	74	75	76	77	78	79	80	81	82	83	84	85	86	Total
6. Mental illness															
Revoke license															
Suspend license															
Reprimand															
Dismiss															
Suspend penalty															
Restriction															
Counselling															
Other															
Sub-total															
7. Interpersonal problems															
Revoke license															
Suspend license															
Reprimand															
Dismiss															
Suspend penalty															
Restriction															
Counselling															
Other															
Sub-total															
8. Miscellaneous															
Poor judgement															
Carelessness															
Abuse of sick time															
Dishonesty															
Unfit to practise											1				1
Illness															
Alcohol & drugs															
Reinstatement															
Total			1				1		1	3	1	5		1	13

Table 6.6

A Summary of Professional Disciplinary Hearings in Newfoundland, 1973-1986

Year	Number	Reason	Penalty
1978	4(1)*	Incompetence	Incompetent act; no penalty
1978	4(1)*	Conduct unbecoming	No breach
1982	1	Incompetence	Not proven; letter with recommendations
1982	1	Incompetence	Suspended license for 21 days
1982	1	Dishonesty & Habit or illness	Suspended license for one year
1983	1	Conduct unbecoming	Revoked right to license and name struck from Register
1984	1	Incompetence & conduct unbecoming	License suspended for 9 months
1984	1	Habit or illness & Conduct unbecoming	No penalty - illness
1985	1	Conduct unbecoming	No breach
1986	1	Incompetence	License suspended for 10 days
1986	1	Default payment of fees	Warning

*Four disciplinary hearings were held involving one nurse.

Incompetence	4
Professional misconduct (conduct unbecoming)	3
Incompetence and professional misconduct	1
Dishonesty, habit, or illness	2
Default payment of fees	1

The disciplinary actions associated with unacceptable nursing behaviours are: revocation of license (1), suspension of license (4), reprimand (2), no penalty or breach (4).

Northwest Territories

The Northwest Territories Registered Nurses' Association (L. Richard, Executive Director/Registrar, personal communication, May 26, 1987) reported that during the period 1973-1986 only one professional discipline case was heard. A nurse was suspended for a period of three years for professional misconduct. The charges were as follows:

1. Administered chloromycetin intravenously to the wrong patient.

2. Administered 20 cc of interlipid in a two hour period when the patient should have received 30 cc per day.

3. Medication not administered to patient as per physician's order.

4. Failure to pay due care and attention to patient

following a tonsillectomy.

5. Failure to chart nursing care in an appropriate manner.

6. Failure to complete required tasks prior to leaving hospital at conclusion of shift.

> The serious nature of these incidents was compounded by the nurse's failure to acknowledge the importance of the errors, to ask questions of more experienced colleagues, and to function effectively as part of the nursing team.

Nova Scotia

The Registered Nurses' Association of Nova Scotia (J. Mills, Executive Director, personal communication, August 17, 1987) reported that during the period 1973-1986, 21 investigations were conducted and 9 formal disciplinary hearings were held related to incompetence, medication errors, and drug or alcohol abuse. The disciplinary actions associated with unacceptable nursing behaviours are: revocation of license (1), suspension of license (6), counselling (1), and re-training (1).

Ontario

The College of Nurses of Ontario (B. J. Secord, Senior Executive Officer, Registration, personal communication, July 31, 1987) reported that during the period 1975-1985, a total of 1,264 complaints were received. Secord (1987) outlines the difference in professional discipline between Ontario and other provinces.

> The structure of the College of Nurses differs from that of other provinces. The Registered Nurses' Association of Ontario is the professional body, the Ontario Nurses' Association is the union, and the College of Nurses is the statutory legislative body which is responsible for the registration of nurses and nursing assistants. Ontario is a large province thus we have a large register, we therefore have more people appear before our Registration and Discipline Committee than do most provinces. The Health Discipline Act splits the discipline function in two. Persons who are charged with professional misconduct or incompetence appear before the Discipline Committee. Persons who are incapacitated or have a health problem appear before the Registration Committee. It was the belief at the time the legislation was passed that an individual should not be penalized because he was ill. (p. 1)

A summary of professional discipline decisions by the Discipline Committee for the period 1975-1985 is in Table 6.7. A breakdown of the cases is as follows:

Incompetence	80
Professional misconduct	100
Professional misconduct and incompetence	50

The disciplinary actions associated with unacceptable nursing behaviours are: revocation of license (77), suspension of license (38), reprimand (47), dismiss (37), restrict license (2), and other (20).

The 21 professional discipline cases forwarded to the investigator relate to decisions by the Discipline Committee during the period 1983-1986. The majority of cases related to professional misconduct. Each case is described outlining the unacceptable nursing behaviours and the disciplinary actions.

Table 6.7

A Summary of Professional Discipline Cases in Ontario, 1975-1986

Reason	73	74	75	76	77	78	79	80	81	82	83	84	85	86	Total
Number of complaints			37	94	116	78	96	114	79	127	171	192	160		1,264
Dismissal of complaints															
Disciplinary action															
1. Incompetence															
Revoke license			5	5	2	5	10	3	1	1	2		1		35
Suspend license				2	5	5	1		2						15
Reprimand				1	6				1						8
Dismiss			1	1	5	3	4	1							15
Suspend penalty															
Restriction								1							1
Counselling															
Other			4	1					1						6
Sub-total			10	10	18	13	15	5	5	1	2		1		80
2. Professional misconduct															
Revoke license			1	4	4	2	3	2	3	1		3	1		24
Suspend license							5	2	3		1	3	2		16
Reprimand			2	3	1	3	8	2	1		8	3	4		35
Dismiss			2		1		2			1	1		5		12
Suspend penalty											1	2	5		8
Restriction															
Counselling															
Other			1	2								1	1		5
Sub-total			6	9	6	5	18	6	7	2	11	12	18		100
3. Professional misconduct and incompetence															
Revoke license			1	3		4	5	1	1	1	1	1			18
Suspend license			1	1	1	1	1		1	1					7
Reprimand			1	2			1								4
Dismiss			2		1			2	1		2	2			10
Suspend penalty											1				1
Restriction									1						1
Counselling															
Other									9						9
Sub-total			5	6	2	5	7	13	3	2	4	3			50
4. Alcohol abuse															
Revoke license															
Suspend license															
Reprimand															
Dismiss															
Suspend penalty															
Restriction															
Counselling															
Other															
Sub-total															
5. Drug abuse															
Revoke license															
Suspend licence															
Reprimand															
Dismiss															
Suspend penalty															
Restriction															
Counselling															
Other															
Sub-total															

Table 6.7 (Continued)

Reason	73	74	75	76	77	78	79	80	81	82	83	84	85	86	Total
6. Mental illness															
Revoke licence															
Suspend licence															
Reprimand															
Dismiss															
Suspend penalty															
Restriction															
Counselling															
Other															
Sub-total															
7. Interpersonal problems															
Revoke licence															
Suspend licence															
Reprimand															
Dismiss															
Suspend penalty															
Restriction															
Counselling															
Other															
Sub-total															
8. Miscellaneous															
Poor judgement															
Carelessness															
Abuse of sick time															
Dishonesty															
Unfit to practise															
Illness															
Alcohol & drugs															
Reinstatement															
Total			21	25	26	23	40	24	15	5	17	15	19		230

Incompetence.

Case 1 (1985). The unacceptable nursing behaviours included: (1) failure to demonstrate knowledge, skill or judgement in areas of catheterization, intravenous administration and medication administration, and (2) failure to provide leadership under stressful situations. The certificate of competence was revoked.

Professional misconduct.

Case 1 (1986). The unacceptable nursing behaviours included: (1) failure to follow physician's orders, (2) failure to follow policies and procedures, and (3) failure to ensure the safe administration of medication. The disciplinary actions imposed were: (1) successful completion of a refresher course, (2) submission of satisfactory performance appraisals from the employer, and (3) practise restricted to administering non-prescription drugs.

Case 2 (1986). The unacceptable nursing behaviours included: (1) falsification of records in relation to urine testing for diabetic patients and the time at which antibiotics were administered, and (2) employed as a registered nurse in one setting while on paid sick leave from another setting. The disciplinary action imposed was successful completion of a refresher course and a fine of two hundred dollars.

Case 3 (1986). A nurse received a reprimand for misappropriation of morphine.

Case 4 (1985). The unacceptable nursing behaviours included: (1) failure to ensure the safe administration of medication, (2) failure to document in an appropriate manner, and (3) failure to utilize a problem-solving approach. The disciplinary actions imposed were: (1) reprimand, and (2) restricted from practise until the successful completion of a course in interpersonal relations and communication skills.

Case 5 (1985). The unacceptable nursing behaviours included: (1) failure to ensure safe administration of medication, and (2) failure to transcribe physician's orders in correct manner. A reprimand was issued.

Case 6 (1985). The unacceptable nursing behaviours included: (1) physical and verbal abuse of residents on several occasions, (2) failure to collaborate with other members of the nursing team, (3) failure to provide for the safety and well-being of the residents, and (4) failure to follow the policies on documentation. The certificate of competence was revoked.

Case 7 (1985). The unacceptable nursing behaviours included: (1) failure to ensure the safe administration in medication, (2) failure to follow institutional procedures when administering a gastric feed, (3) failure to assess a patient's status, (4) failure to report a change in the patient's status, (5) failure to collaborate with other member of the health care team in providing care, and (6) failure to correct a record. The nurse was suspended until the successful completion of the New Start Nursing program. Further, the nurse was required to present a satisfactory performance appraisal by the employer.

Case 8 (1985). The unacceptable nursing behaviours included: (1) failure to ensure the safe administration of medications, (2) failure to record pertinent information on patients' records (vital signs, intake and output, patient teaching and anatomical descriptions), and (3) failure to carry out an assigned task, i.e., dressing. The certificate of competence was suspended until a refresher course was completed.

Case 9 (1985). The unacceptable nursing behaviours included a failure to ensure the safety and well-being of infants in relation to nasogastric feedings, intravenous therapy, oxygen administration, suctioning and documentation of care. The certificate of competence was suspended. A nursing refresher course with a clinical component was to be successfully completed prior to re-registration.

Case 10 (1985). The unacceptable nursing behaviours included: (1) failure to ensure the safe administration of medication, and (2) failure to provide for the safety and well-being of patients undergoing dialysis. The actions imposed were: (1) certificate of competence suspended for a period of two years until a refresher course with clinical component successfully completed, (2) satisfactory references from employer, and (3) restricted from performing dialysis procedures until the above conditions were met.

Case 11 (1984). This nurse was found guilty by the Board of Examiners of the State of Texas for signing out medications on the Controlled Substance Administration Record for dosages in excess of those prescribed on the physician's order sheet. The certificate of competence in Ontario was revoked.

Case 12 (1984). The unacceptable nursing behaviours included: (1) failure to ensure the safe administration of medications, (2) failure to follow established policies and procedures in relation to intravenous therapy, (3) failure to attend to duties, i.e., absence from the unit while on duty and habitual lateness, and (4) misappropriation of a drug. A reprimand was issued.

Case 13 (1984). The unacceptable nursing behaviours included: (1) physical and verbal abuse of residents, and

(2) failure to follow prescribed treatments for residents. The certificate of competence was revoked.

Case 14 (1984). The nurse failed to ensure the safe administration of medication. The certificate of competence was suspended until a refresher program was completed.

Case 15 (1984). The nurse was charged with uttering two forged documents and committing perjury at a Registration Committee hearing. The certificate of competence was revoked and the nurse was fined five hundred dollars.

Case 16 (1984). The unacceptable nursing behaviours included: (1) failure to ensure the safe administration of medications, (2) failure to follow established policies and procedures in relation to intravenous therapy, (3) failure to document in an appropriate manner, (4) failure to carry out physicians' orders, and (5) errors in judgement in patient care. The certificate of competence was suspended until the successful completion of a medical-surgical refresher course.

Case 17 (1984). The unacceptable nursing behaviours included: (1) failure to ensure the safe administration of medication, and (2) failure to provide for the safety and well-being of patients. The nurse was to continue professional therapy and submit an annual report to the college for renewal of certificate.

Case 18 (1984). Unacceptable nursing behaviours included: (1) failure to transcribe physician's orders correctly, (2) failure to record the administration of medications accurately, (3) failure to record daily blood pressures, (4) failure to record the condition of a patient who had fallen, (5) failure to follow established policies and procedures of an organization, and (6) failure to ensure the safe administration of medications. The certificate of competence was suspended until a refresher course with a clinical component was successfully completed.

Professional misconduct and incompetence.

Case 1 (1984). The unacceptable nursing behaviours included: (1) failure to maintain the standards of nursing practise by abandoning patients, (2) mildly abusing patients physically, (3) unprofessional language and demeanour, (4) failure to adhere to policies of an organization by assigning a registered nursing assistant to process physicians' orders and co-signing the orders without having checked the accuracy of the transcriptions, and (5) failure to provide verification of an annual physical examination thus violating the agency's legislative requirements. The certificate of competence was revoked.

Case 2 (1983). The unacceptable nursing behaviours included: (1) failure to ensure the safe administration of medications, (2) falsification of a record in relation to the medication, (3) initiating and carrying out an action without a physician's order and failure to record this action, (4) failure to meet the standards of nursing practise in the assessment of a patient and the documenting of the condition of the patient, (5) inaccurately recording the administration of a medication, (6) failure to conduct nursing rounds on one occasion, (7) failure to notify the physician of a change in the resident's condition in a nursing home, and (8) mildly abusing two patients physically and verbally. The certificate of competence was revoked.

A total of 21 cases were described involving incompetence (1), professional misconduct (18), and professional misconduct and incompetence (2). In the case of incompetence, the unacceptable nursing behaviour was failure to demonstrate knowledge, skill or judgement in areas of catheterization, intravenous administration and medication administration. The certificate of competence was revoked. The two cases described involving professional misconduct and incompetence also resulted in the certificates of competence being revoked for (1) patient abandonment, (2) physical abuse of patients, (3) unprofessional language and demeanour, (4) failure to adhere to policies of an organization, (5) medication administration errors, (6) falsification of records, and (7) initiating actions without a physician's order.

Of the 18 cases of professional misconduct a further breakdown is as follows:

Medication administration errors	11
Patient abuse	2
Misappropriation of drugs	2
Falsification of records	1
Failure to provide for the safety and well-being of patients	1
Uttering forged documents	1

A summary of the disciplinary actions imposed by the professional association in each of the above categories follows. In those professional discipline cases involving

1. medication administration errors, the nurse reaceived a reprimand or a suspension until the completion of a refresher course;

2. patient abuse, the nurses both had their certificate of competence revoked;

3. misappropriation of drugs, one nurse received a reprimand although the reason why was not cited and the other nurse had her certificate of competence revoked;

4. falsification of records, the practise of the nurse was restricted to administering non-prescription drugs and the nurse was also required to complete a refresher course;

5. failure to provide for the safety and well-being

of patients, the nurse was required to complete a refresher course;

6. uttering forged documents, the nurse had her certificate of competence revoked.

Prince Edward Island

The Association of Nurses of Prince Edward Island (S. Maclure, Executive Director, personal communication, May 20, 1987) reported that three investigations were conducted all for drug abuse during the period 1973-1986.

Quebec

The Order des Infirmieres et Infirmiers du Quebec (N. Corbin, Syndic, personal communication, July 21, 1987) provided the investigator with annual reports during the period 1973 to 1986 in regards to the activities of the Committee on Discipline and the Syndic's department. The reports and accompanying selected cases were translated by the Faculté Saint-Jean, University of Alberta. The method of reporting information changed in 1978 and became increasingly more detailed. Up until that point the classification of cases was as follows: imposters, illegal practise, drug problems, professional ethics, health problems, incompetence and a miscellaneous category. During the period 1976 the complaints were as follows: imposters (4), illegal practise (2), drug problems (7), professional ethics (18), health problems (5), and incompetence (2). During the period 1977 the complaints were: imposters (3), illegal practise (19), drug problems (10), professional ethics (24), health problems (6), incompetence (1), and miscellaneous (1).

In Table 6.8, complaints received during the period 1978-1984 and the disciplinary actions invoked are presented. In this period, a total of four hundred complaints were received, the majority of cases relating to: misappropriation of drugs, narcotics, or anaesthetics from an employer; acting in a manner generally not accepted by the profession; voluntarily abandoning a patient who requires supervision and practising while under the influence of drugs, alcohol or narcotics. The disciplinary actions imposed were: revocation of license (3); temporary loss of registration(19); permanent loss of registration (7); reprimand (20); and fines imposed (11).

The 14 selected professional cases forwarded to the investigator relate to professional misconduct. Each case is described in abstracted form outlining the unacceptable nursing behaviours and the disciplinary actions. All the cases involved professional misconduct.

Professional misconduct.

Case 1 (1986). The unacceptable nursing behaviour was practising under the influence of drugs. The disciplinary actions imposed were: (1) a rehabilitation program, and (2) temporary loss of registration for a six month period.

Table 6.8

Professional Discipline Charges in Quebec, 1978-1985*

Article	Reason	78	79	80	81	82	83	84	Total
3.01.01	Personal limitations			1			32		33
3.06.01	Respect of confidentiality			1		1	1		3
3.06.06	A professional must not use confidential information against the client to his personal advantage			2					2
4.01.01(b)	To practice under the influence of drugs, alcohol, narcotics	5	5	1	6	19	3	18	57
4.01.01(c)	To take drugs, narcotics, or anaesthetics from an employer	3	4	1	2	9	40	54	113
4.01.01(e)	To permit any person who is not entered on the role of the Order to practice the profession	2		1					3
4.01.01(f)	To voluntarily abandon a client who requires supervision or to refuse to provide services without sufficient reason		1		16	1	39	1	58
4.01.01(g)	To act in a manner not generally accepted by the profession	8	12	5	8	7	13	28	81
4.01.01(h)	To enter false items in a client's record or to insert notes under another's signature.	2			1	2	27	1	33
4.01.01(i)	Changing records to alter intent	1	4		1				6
4.01.01(l)	To communicate with a plaintiff when individual is advised of charge			1					1
	Miscellaneous	5	1	4					10
	Total	26	27	17	34	39	155	102	400

Disciplinary Actions

Disciplinary Actions	78	79	80	81	82	83	84	Total
Revocation of license		2					1	3
Temporary loss of registration	3	4	3		1	5	3	19
Permanent loss of registration	2	2	2			1		7
Reprimand	2	3	7	3	1	1	3	20
Fine	1	6	2		1		1	11

*Translated by Faculté Saint-Jean, University of Alberta.

Case 2 (1986). The nurse failed to administer a medication in a safe and competent manner. Since the nurse had been assigned to relieve in the emergency department and was not familiar with the policies and procedures, a reprimand was issued.

Case 3 (1986). The unacceptable nursing behaviour was practising under the influence of alcohol. The disciplinary actions were: (1) a rehabilitation program, and (2) permanent loss of registration. The nurse may apply for registration following a successful rehabilitation program.

Case 4 (1985). The unacceptable nursing behaviours included: (1) failure to provide care in an intensive care unit because she followed an order from the union, and (2) abandoned duties without sufficient reason. A reprimand was issued.

Case 5 (1985). The unacceptable nursing behaviours included: (1) failure to act in a manner generally accepted by the profession, and (2) failure to administer medications in a safe and competent manner. The disciplinary action was a temporary loss of registration for a period of six months.

Case 6 (1984). The unacceptable nursing behaviours included: (1) administration of medication without a physician's order, (2) failure to update patient's chart, and (3) practising while under the influence of drugs. A loss of registration for a three year period was issued.

Case 7 (1984). The unacceptable nursing behaviours included: (1) failure to attend duties on time, and (2) failure to act in a manner generally accepted by the profession. The disciplinary action imposed was permanent loss of registration.

Case 8 (1984). The unacceptable nursing behaviours included: (1) misappropriation of drugs from the employer, and (2) failure to act in a manner generally accepted by the profession. A reprimand was issued.

Case 9 (1984). The unacceptable nursing behaviours included: (1) failure to act in a manner generally accepted by the profession, and (2) failure to follow policies and procedures in regards to charting, i.e., updating files with incorrect information. A reprimand was issued.

Case 10 (1980). The unacceptable nursing behaviours included: (1) practising under the influence of alcohol, and (2) failure to act in a manner generally accepted by the profession. The disciplinary actions were: (1) a rehabilitation program, (2) a temporary loss of registration for a period of one year, and (3) presentation of a medical certificate prior to being re-certified.

Case 11 (1979). The unacceptable nursing behaviours included: (1) physical abuse of patients, (2) blackmail, (3) failure to update the patients' files, and (4) failure to administer medications in a safe and competence manner. The license was revoked.

Case 12 (1979). The unacceptable nursing behaviours included: (1) drug abuse, and (2) failure to act in a manner generally accepted by the profession. The disciplinary action was permanent loss of registration.

Case 13 (1979). The unacceptable nursing behaviours included: (1) practising under the influence of alcohol, and (2) failure to act in a manner generally accepted by the profession, i.e., forgot to give a number of medications and administered a medication without a physician's order. The disciplinary action was a temporary loss of registration for a period of five months.

Case 14 (1978). The unacceptable nursing behaviours included: (1) failure to carry out assigned tasks and responsibilities, and (2) failure to administer medications in a safe and competent manner. The disciplinary action was temporary loss of registration for a period of six months.

A total of 14 cases involving professional misconduct were described. Of the cases examined, a further breakdown is as follows:

Medication administration errors	3
Patient abuse and blackmail	1
Patient abandonment	1
Misappropriation of drugs	1
Practising while under the influence of alcohol or drugs	5
Failure to act in a manner generally acceptable by the profession	2
Failure to carry out assigned tasks	1

A summary of the disciplinary actions imposed by the professional association in each of the above categories follows. In those professional discipline cases involving

1. medication administration errors, one nurse received a reprimand since she was not familiar with the practises in the emergency department, one nurse received a temporary loss of registration, and the other nurse received a loss of registration for a period of three years since she was also practising under the influence of drugs;

2. patient abuse and blackmail, the nurse had her certificate of competence revoked;

3. patient abandonment, the nurse received a reprimand;

4. misappropriation of drugs, the nurse received a reprimand;

5. practising while under the influence of alcohol or drugs, three nurses received a loss of registration until a rehabilitation program had been successfully completed, one nurse received a loss of registration for six months, and the other nurse received a permanent loss of registration;

6. failure to act in a manner generally accepted by the profession, one nurse received a reprimand and the other nurse received a loss of registration;

7. failure to carry out assigned tasks, the nurse received a temporary loss of registration.

Saskatchewan

The Saskatchewan Registered Nurses' Association (E. Necker, Registrar, personal communication, July 1987) reported that information in regards to professional discipline matters was not tabulated. Annual reports for 1985 and 1986 were forwarded to the investigator. The committee on discipline for registered nurses, which was newly structured through a 1984 bylaw change, met eight times in 1985. Council discussions resulted in one license being revoked, two suspensions of license, one reprimand and one severe reprimand (Annual Report, 1985, p. 8). The committee on counselling received three requests, however, following correspondence and interviews, all cases were resolved and declared dismissed.

The investigation committee received twelve written complaints during 1986. One case was referred to the committee on counselling and five cases were referred to the committee on discipline (Annual Report, 1986, p. 8). The committee on discipline for registered nurses met four times in 1986 on matters concerning three registered nurses. Council decisions resulted in one reprimand, one suspension, and one revocation.

Summary

In this chapter, an overview of professional discipline was presented. First, the legislation governing professional discipline was examined and discussed under the following sub-headings: (1) introduction, (2) complaints, (3) investigation, and (4) appeal. A summary of the legislation was incorporated in Table 6.1. Second, definitions of professional misconduct, incompetence and unskilled practise as presented in the relevant legislation were reviewed. As the purpose of the chapter was to determine the types of nurse behaviours which resulted in disciplinary action by the professional association, a selected review of professional discipline cases in each province during the period 1973-1986 was presented.

It was found that:

1. definitions for professional misconduct are in the relevant professional acts or by-laws in Alberta, Nova

Scotia, Quebec, and Saskatchewan;

2. the professional act in the Northwest Territories provides a definition of improper conduct although this definition resembles the definition of professional misconduct in other provinces;

3. the complaints procedure varied in that complaints are directed toward the Executive Director in some provinces and the territories (Alberta, New Brunswick, Saskatchewan, and the Northwest Territories) while in other provices complaints are directed to an investigations officer, a complaints committee or the discipline committee;

4. the investigation procedure varies in the provinces and territories. In several provinces, the complaint is processed by the investigation (complaints) committee and then the discipline committee. In Ontario, the discipline committee considers matters concerning incompetence and professional misconduct while the registration committee deals with alcohol and drug related misdemeanours;

5. the appeal process varies. In some provinces the nurse appeals to the appeals committee or the board of directors while in other provinces and territories the appeal may be to the provincial court or the Minister of Labour.

In the cases examined it was found that:

1. incompetence is a serious charge and has led to

the revocation of the license in two of the cases;

2. professional misconduct covers a wide range of areas including medication administration errors, patient abuse (physical and verbal), patient abandonment, misappropriation of drugs, falsification of records, failure to provide for the safety of a patient, failure to act in a manner generally acceptable to the profession and other unacceptable behaviours.

Of the professional discipline cases examined involving

1. medication administration errors, nurses received a reprimand or a suspension of license until the completion of a refresher course;

2. patient abuse (physical or verbal), nurses in all cases had their certificate of competence revoked;

3. patient abandonment, the nurses, depending on the circumstances of the case, received either a reprimand or had the certificate of competence revoked;

4. misappropriation of drugs, depending on the circumstances, the nurses received either a reprimand or had the certificate of competence revoked;

5. falsification of records, the practise of the nurse was restricted to the administration of non-prescription drugs until a refresher course had been successfully completed;

6. failure to provide for the safety and well-being of the patients, the nurse was required to complete a

refresher course;

7. uttering forged documents, the nurse had her certificate of competence revoked;

8. practising while under the influence of alcohol or drugs, in most instances the nurses received a suspension of license or loss of registration until a rehabilitation program had been successfully completed;

9. failure to act in a manner generally acceptable to the profession, depending on the circumstances, the nurse received either a reprimand or a temporary loss of registration.

Professional discipline is complex and the outcome is dependent upon the definition as cited in the relevant professional nursing act, the circumstances surrounding the case, the outcome of previous cases heard in the relevant province or territory, the past performance of the nurse, and the potential for rehabilitation. The key point stressed by several nursing executives of professional associations is that the discipline should be consistently applied. Several provinces are now sharing appropriate information with their counterparts.

In Chapter 7, an analysis of the findings will be conducted.

Chapter 7

ANALYSIS OF THE FINDINGS

Introduction

The purpose of this chapter is to present an analysis of the findings based upon the sub-problems of the study which are:

1. To determine the types of nurse behaviours which resulted in negligence lawsuits and the legal consequences of these behaviours.

2. To determine from arbitration cases, the types of nurse behaviours which resulted in suspension or termination from employment and the arbitral consequences of the behaviours.

3. To determine the types of nurse behaviours which resulted in disciplinary action by the professional association.

4. To provide operational definitions of negligence, incompetence, unskilled practise and professional misconduct based upon the findings of the study.

For sub-problems 1-3, the procedure is as follows: first, the sub-problem is stated. This is followed by a summary of the number of cases examined in each category. The unacceptable nursing behaviours identified from the cases are then reviewed.

Following the final statement of the sub-problem, the operational definitions for negligence, incompetence, unskilled practise, and improper conduct based upon legal definitions, and definitions cited in arbitration cases and professional legislation are presented. Finally, a review is provided of unacceptable nursing behaviours as identified from the findings of this study.

Legal Cases

Sub-Problem #1: To determine the types of nurse behaviours which resulted in negligence and the legal consequences if these behaviours.

Twenty-four civil and criminal cases involving negligence were examined for the period 1904-1986. The breakdown is as follows:

Civil lawsuits involving negligence	21
Civil lawsuits involving dismissal	2
Criminal lawsuit and a public inquiry	1

Types of nurse behaviours identified in the cases were divided into two major categories, civil lawsuits and criminal lawsuits. The civil lawsuit category was further divided into negligence (patient related, medication related, and procedure related) and dismissal cases.

In Table 7.1, the number of legal cases of the various types for each province or territory are presented.

The unacceptable nursing behaviours identified in the civil lawsuits were of the following types: patient

Table 7.1

Types of Legal Cases Involving Canadian Nurses During the Period 1904 through 1987

Reason	Alta	BC	Man	NB	Nfld	NWT	NS	Ont	PEI	Que	Sask	Total
Civil Lawsuits												
Negligence												
Patient related												
Assessment												
General	2							1				3
Post-operative		2						1				3
Medication related												
Procedure for injection		1						1				2
Medication administration	1		1	1			1					4
Procedure related	3	2						2			2	9
Dismissal cases			1								1	2
Criminal Lawsuit and Public Inquiry								1				1
Total	6	5	2	1			1	6			3	24

related, medication related, and procedure related. A further breakdown is provided below:

Unacceptable Nursing Behaviours Identified in Patient Related Cases

- failure to assess patient in a systematic manner;
- failure to report changes in a patient's condition to the attending physician;
- failure to notify oncoming staff that the patient should be monitored closely;
- failure to provide an established standard of care to a patient following a spinal fusion;
- failure to monitor the vital signs and fluid intake/output at established intervals;
- failure to chart patient's condition;
- failure to exercise established manner of care for an epileptic patient;
- failure to return from coffee breaks in time to check the patient's condition;
- failure to ensure that the unit was adequately staffed prior to leaving for a coffee break;
- failure to place the patient in a position where he could be closely monitored.

Unacceptable Nursing Behaviours Identified in Medication Related Cases

- Failure to ensure that the correct medication was administered to the patient;
- failure to ensure that the intramuscular injection

was given in the correct manner;
- failure to ensure that the correct medication was given to the physician to administer to a patient;
- failure to ensure that the correct solution of medication was administered to the patient.

Unacceptable Nursing Behaviours Identified in Procedure Related Cases

- failure to secure assistance from another staff member in elevating the head of the patient's bed;
- failure to exercise caution when weighing an infant;
- failure to ensure that the temperature of the water placed in hot water bottles was in accord with established practices;
- failure to obtain physician's order prior to administering a procedure;
- failure to administer correct dosage of diathermy;
- failure to exercise due care and attention when administering inhalation therapy.

Nurses are facing lawsuits for: (a) failure to provide an established standard of care, (b) failure to administer medication following established hospital policies and procedures, (c) failure to carry out a procedure according to established hospital policies and procedures, (d) failure to document the patient's record in an appropriate manner, and (e) failure to ensure that the unit has adequate staff coverage prior to leaving for a break.

The next sub-problem to be reviewed is arbitration cases.

Arbitration Cases

> Sub-Problem #2: To determine from arbitration cases, the types of nurse behaviours which resulted in suspension or termination from employment and the arbitral consequences of these behaviours.

A total of 40 arbitration cases were examined during the period 1973-1987. Of this total, there were 5 suspensions and 34 dismissals; one case was inarbitrable. A further breakdown of information is as follows:

Suspensions (Total 5)	
Upheld	4
Reinstated to position	1
Dismissals (Total 34)	
Upheld	7
Reinstated	27

A summary of arbitration cases involving suspension of employment during the period 1973-1986 is presented in Table 7.2. Three cases involved insubordination, one case involved neglect of duty (sleeping on the job), and one case involved exceeding the allotment for sick time.

A summary of the cases examined involving dismissal from employment during the period 1973-1986 in each provincial jurisdiction is presented in Table 7.3. An overview of the cases is as follows:

Table 7.2

A Summary of Arbitration Cases Involving Suspension of Employment Among Nurses in Canada for the Period 1973 through 1986

Reason	Alta	BC	Man	NB	Nfld	NWT	NS	Ont	PEI	Que	Sask	Total
Incompetence												
General												
Medication errors												
Insubordination								3				3
Neglect of Duty								1				1
Professional Misconduct												
Theft												
Breach of confidentiality												
Force-feeding												
Criminal conviction												
Patient abuse												
Falsification of employment records												
Absenteeism												
General								1				1
Illness												
Use of Alcohol and Drugs												
Dismissal on Religious Grounds												
Miscellaneous Cases												
Total								5				5

Table 7.3

A Summary of Arbitration Cases Involving Dismissal from Employment Among Nurses in Canada for the Period 1973 through 1986

Reason	Alta	BC	Man	NB	Nfld	NWT	NS	Ont	PEI	Que	Sask	Total
Incompetence												
General		1	2					1		1		5
Medication errors							1	4			2	7
Insubordination			1									1
Neglect of Duty							1					1
Professional Misconduct												
Theft			1									1
Breach of confidentiality								1				1
Force-feeding			1									1
Criminal conviction								1				1
Patient abuse		2										2
Falsification of employment records					1							1
Absenteeism												
General								1				1
Illness		1		1				5			1	8
Use of Alcohol and Drug Cases		1										1
Dismissal on Religious Grounds								1				1
Miscellaneous Cases			1						1			2
Total	--	5	6	1	1	--	2	14	1	1	3	34

Incompetence (12)	
General	5
Medication errors	7
Insubordination	1
Neglect of duty	1
Professional misconduct	7
Absenteeism	9
Use of alcohol and drug cases	1
Dismissal on religious grounds	1
Miscellaneous	2

The unacceptable nursing behaviours identified in the professional discipline cases were of the following types: incompetence, medication errors, insubordination, neglect of duty, professional misconduct, absences (general and illness), use of alcohol and drug cases, religious grounds, and miscellaneous cases. A detailed breakdown of these types of cases is provided below.

Incompetence

- failure to follow established policies and procedures for provision of proper care;
- failure to follow physician's orders;
- failure to follow hospital rules and regulations in regards to reporting to the hospital unit prior to reporting to the health service;
- failure to fulfill duties as a charge nurse;

- failure to fulfill responsibilities to patients assigned to her during the shift;
- failure to advise unit staff of duration of absence from unit and of whereabouts during absence;
- failure to exercise due care and attention for a suicidal patient;
- failure to communicate changes in patient's condition with other members of the health care team;
- failure to follow established policies and procedures in regards to administrative tasks, i.e., patient classification forms, ordering of supplies, changes in nursing care plans;
- failure to cope with changes in policies and procedures;
- failure to upgrade knowledge or provide a plan for improving nursing skills;
- failure to follow established policies and procedures in regards to sterile technique;
- failure to follow established policies and procedures in regards to blood administration and patient care.

Medication errors

- failure to follow established procedures in medication administration;

- failure to follow standard reporting procedures for drug errors;
- failure to recognize the gravity of serious breaches of employment obligations;
- failure to update nursing care plans with new physicians' orders;
- failure to note changes in physician's orders;
- failure to ensure that nursing students were following established policies and procedures in respect to medication administration.

Insubordination

- failure to follow a directive from administration to "float" to a unit where a spouse was the director;
- failure to accept care for a critically ill patient;
- failure to follow orders as directed by management;
- failure to follow established policies and procedures in regards to appointing a nurse in charge;
- failure to report to management circumstances of an incident, involving refusal to care for a patient.

Neglect of Duty

- failure to perform duties in accordance with established policies, procedures, rules and regulations as a result of sleeping on the job.

Professional Misconduct

- failure to follow established manner of conduct in regards to the following: slapping an aggressive disabled patient, theft from the employer, "tapping" a child who was misbehaving on the cheek, rough handling of a patient;
- failure to notify present employer that she was dismissed from previous employment prior to completion of the probationary period;
- failure to adhere to principles of disclosure of confidential information.

Absences

General

- failure to inform employee that she would not be returning to her position until two months later than scheduled.

Illness

- failure to provide patients with a safe environment as a result of recurrent sleep episodes;
- failure to ensure safety of employer's property,

for example, driving an automobile and undergoing an insulin reaction;

- failure to attend to duties as a result of recurrent back problems;
- failure to perform contractual obligations by not attending to duties when scheduled because of repeated illness.

Alcohol and Drug Related Cases

- failure to adhere to established manner of conduct expected of a professional, i.e., drinking on the job.

Dismissal on Religious Grounds

- failure to perform an integral part of duties in regards to blood administration, based on religious beliefs.

Miscellaneous Cases

- failure to behave in a manner acceptable as professional registered nurse, i.e., unable to work cooperatively with other members of the health care team;
- failure to inform employer that swabs of an unclean kitchen area had been sent to the lab for analysis.

Nurses have been suspended or terminated from employment for incompetence, medication errors, insubordination, neglect of duty, professional misconduct, absenteeism, abuse of alcohol and drugs, dismissal on religious grounds and for miscellaneous reasons. Arbitrators have stressed that nurses are held more accountable for their actions on the basis of their professional responsibilities.

Professional Discipline Cases

> Sub-Problem #3: To determine the types of nurse behaviours which resulted in disciplinary action by the professional association.

In Table 7.4, a summary of the professional discipline cases heard by the Discipline Committee in each provincial jurisdiction or territory during the period 1973-1986 is presented. It should be noted that the numbers presented do not reflect the total number of cases heard for the following reasons:

1. reporting mechanisms vary widely in each provincial jurisdiction;

2. information received from the province of Quebec was not sufficient to enable a detailed breakdown of the cases in the summary table, in particular because the method of reporting changed in 1978 and the information is now reported according to articles of the Nursing Profession Ordinance (1975, s. 23) breached, i.e., confidentiality, patient abandonment, and practising under the influence of drugs;

3. information received from the province of Ontario

Table 7.4

A Summary of Professional Discipline Cases Heard by the Discipline Committee in Each Provincial Jurisdiction and the Territories During the Period 1973 through 1986[1]

Reason	Alta	BC[2]	Man	NB[3]	Nfld	NWT	NS[4]	Ont[5]	PEI	Que[6]	Sask[7]	Total
Incompetence	3		4		4			80				
Professional misconduct	3		3		3	1		100				
Professional misconduct and incompetence					1			50				
Alcohol related	6											
Drug related	37		~~5~~						3			
Mental illness	11											
Interpersonal problems	3											
Miscellaneous	15		1		3							
Total	78	135	13		11	1	21	230	3	400		892

[1] Reporting mechanisms differ in the various provincial jurisdictions and the territories.

[2] British Columbia reported a total of 135 cases by the Discipline Committee. Please refer to p. 271.

[3] Information from New Brunswick was not received.

[4] Nova Scotia reported that 21 investigations were carried out relating to incompetence, medication errors, and drug or alcohol abuse.

[5] In the province of Ontario persons who are charged with incompetence or professional misconduct appear before the Discipline Committee, persons who are incapacitated or have a health problem appear before the Registration Committee. Cases presented relate to those heard by the Discipline Committee only and are limited to the years 1975-1986.

[6] The total number of cases is reflective of articles breached in the Professional Code and Nurses' Act during the period 1978-1986.

[7] Information from Saskatchewan was not received.

relates only to those cases heard by the Discipline Committee in regards to incompetence and professional misconduct;

4. information was not received from New Brunswick, Saskatchewan or the Yukon;

5. the mechanisms for classifying medication errors vary from province to province. In Ontario and Quebec medication errors are classified under professional misconduct. In other provinces, medication errors are classified as a sub-category of incompetence.

In total, 43 discipline cases were examined from information received from British Columbia, the Northwest Territories, Ontario and Quebec. The cases involved incompetence (3); professional misconduct (37); and both professional misconduct and incompetence (3). The disciplinary actions imposed by the respective professional associations include:

Revocation of license	10
Suspension of license	16
Reprimand	10
Restriction of practise	4
Counselling	1
Miscellaneous:	
Fine	2
Refresher course	13
Rehabilitation	2
Medical certificate required prior to registration	1

The unacceptable nursing behaviours identified in the arbitration cases were of the following types: incompetence, professional misconduct, and professional misconduct (medication related). Details on specific types of unacceptable nursing behaviours in each category are provided below.

Incompetence

- failure to demonstrate knowledge, skill or judgement in areas of catheterization, intravenous administration and medication administration;
- failure to provide leadership during stressful situations;
- failure to adhere to policies of an organization by assigning a registered nursing assistant to process physician's orders and co-signing the orders without checking the accuracy of the transcription;
- failure to make nursing rounds;
- failure to meet the standards of nursing practise in the assessment and documentation of a patient's condition;
- failure to perform a nursing assessment, complete an admission note, and conduct an assessment at regular intervals of a patient who had a history of miscarriages.
- failure to ensure that the blood administered to a

patient was correctly documented (error in recording transfusion number);

- failure to pay due care and attention to a patient following a tonsillectomy;
- failure to complete required tasks prior to leaving the hospital at the conclusion of a shift;
- failure to acknowledge the importance of errors made in medication administration, failure to document these errors, and failure to request assistance from more experienced colleagues.

Professional Misconduct

- failure to follow physician's orders;
- failure to follow hospital policies and procedures;
- failure to follow hospital policies and procedures in regards to charting, i.e., falsification of records (urine testing for diabetic patients and times at which antibiotics were administered);
- failure to inform employer that she was working in one institution while on paid sick leave from another;
- misappropriation of drugs from the employer;
- failure to use problem-solving approach in patient care;
- failure to transcribe physician's orders in correct manner;

- physical and verbal abuse of residents of a nursing home;
- failure to collaborate with other members of the health care team;
- failure to provide for the safety and well-being of residents of a nursing home;
- failure to follow institutional procedures when administering a nasal gastric feed;
- failure to assess a patient's status;
- failure to report a change in patient's status;
- failure to record information on patient's record including vital signs, intake and output, patient teaching, and anatomical description;
- failure to carry out a procedure (dressing change);
- failure to ensure the safety and well-being of infants in relation to nasogastric feedings, intravenous therapy, oxygen administration, suctioning, and documentation of care;
- failure to provide for the safety and well-being of patients while performing dialysis;
- patient abandonment;
- failure to provide verification of an annual physical examination thus violating the agency's legislative requirements;
- failure to account for unauthorized absences from the unit and unexplained tardiness;

- uttering two forged documents and committing perjury at a Registration Committee hearing;
- failure to record the condition of a patient who had fallen;
- practising under the influence of drugs or alcohol;
- blackmail of a patient;
- failure to provide care in an intensive care unit because of a directive from the union;
- failure to pay attention to duties and responsibilities.

Professional Misconduct (Medication Related)

- failure to ensure the safe administration of medications--20 cases;
- failure to ensure the safe administration of an intravenous solution;
- failure to account for medications listed in the controlled substance administration record which were in excess of the physician's orders;
- failure to receive a physician's order prior to administering a medication.

The unacceptable behaviours identified in the professional discipline cases were incompetence and professional misconduct. For the purposes of this study, medidation errors were analyzed separately and of the 23 cases examined, 20 cases related to the nurse's failure to ensure the safe administration of medication.

Operational Definitions

> Sub-Problem #4: To provide operational definitions of negligence, incompetence, unskilled practise and professional misconduct based upon findings of the study.

In this section, operational definitions of negligence, incompetence, and professional misconduct are presented based upon legal definitions, definitions cited in arbitration cases, and professional legislation.

Negligence

The definition most commonly cited was:

> . . . the omission to do something which a reasonable man guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a reasonable or prudent man would not do. (Blythe v. Birmingham, 1856, p. 784)

As presented earlier in Chapter 4, four elements required to establish a case of negligence as identified by Rozovsky (1974) include:

1. A legal duty on the part of the nurse towards the patient;
2. A failure by the nurse to meet the standard of care and proficiency required by law;
3. An injury to the patient;
4. The patient's injury must have resulted from the negligence of the nurse (adapted from Rozovsky, 1974, p. 74).

In this study, the unacceptable nursing behaviours identified as negligence included the following:

- failure to provide an established standard of care to a patient;
- failure to monitor the patient at regular intervals;
- failure to assess a patient in a systematic manner and report changes to the attending physician;
- failure to document according to established policies and procedures;
- failure to ensure that medication was administered in a safe and competent manner;
- failure to ensure that a procedure was carried out according to established practise;
- failure to ensure that a unit is adequately staffed prior to leaving for breaks.

It is important to note that at least one judge contends that negligence and incompetence are not synonyms and points out the difference between the two. The distinction is made as follows:

> Negligence and incompetence are not interchangeable terms. A competent nurse may sometimes be negligent without being incompetent. However, habitual negligence may amount to incompetence. (Cited in Mason v. Registered Nurses' Association of British Columbia, 1979, p. 24)

Incompetence

Incompetence in nursing legislation has been defined as:

> . . . a lack of knowledge, skill, or judgement or disregard for the welfare of a patient to an extent that demonstrates that the person is unfit to practise. (Health Disciplines Act, 1980, s. 83[5]; Saskatchewan Registered Nurses' Association Bylaws, 1985, xv, s. 2)

Philpott (1985) in her book titled, "Legal liability and the legal process," states:

> To determine what particular behaviours would constitute "incompetence," the wording of the particular act must be examined in light of the facts involved in the particular complaint. If the act does not define incompetence (within the statute itself or in its regulations or by-laws) the courts will give it the meaning generally accepted by society. (p. 146)

The unacceptable nursing behaviours identified in this study as illustrative of incompetence include:

- failure to demonstrate knowledge, skill, or judgement in areas of intravenous administration and medication administration;
- failure to follow established policies and procedures for provision of patient care;
- failure to follow physician's orders;
- failure to adhere to policies of an organization by assigning a registered nursing assistant to process physician's orders and co-signing the orders without checking the accuracy of the transcription;
- failure to perform a nursing assessment and plan of care;
- failure to provide for the patient's safety;
- failure to meet the standards of nursing practise

in the assessment and documentation of a patient's condition;
- failure to follow established policies and procedures in regards to blood administration;
- failure to fulfill responsibilities to assigned patients;
- failure to communicate changes in patient's condition to other members of the health care team;
- failure to fulfill duties as a charge nurse;
- failure to provide leadership during stressful situations;
- failure to follow established policies and procedures in regards to administrative tasks;
- failure to advise other unit staff of duration of absence from unit and whereabouts during absence;
- failure to complete tasks prior to leaving a unit;
- failure to upgrade knowledge or provide a plan for improving nursing skills;
- failure to acknowledge the importance of errors made in medication administration and documentation of same;
- failure to request assistance from colleagues if unsure of a particular practise or when unable to cope with a particular situation.

Unskilled Practise, Improper Conduct or Professional Misconduct

In the Alberta legislation, unskilled practise or professional misconduct is defined as:

> . . . any conduct of a registered nurse or a permitholder that, in the opinion of the Professional Conduct Committee:
> (a) is detrimental to the best interests of the public,
> (b) contravenes this act or the regulations,
> (c) harms the standing of the nursing profession generally,
> (d) displays a lack of knowledge or a lack of skill or judgement in the carrying out of any duty or obligation undertaken as a registered nurse or permit holder whether or not that conduct is disgraceful or dishonourable, constitutes either unskilled practice of professional misconduct or both, whatever the Professional Conduct Committee defines. (Nursing Profession Act, 1983, s. 58)

Incorporated in this definition is unskilled practise, incompetence, and professional misconduct. In other provincial jurisdictions professional misconduct has been defined in light of specific nursing behaviours which are deemed to be "conduct unbecoming to a registered nurse." It is important for nurses to be aware of the definition within their provincial or territorial jurisdiction. The behaviours which have been regarded as derogatory to the profession, as defined in the legislation, include:

- physical or verbal abuse of a patient;
- misappropriating a patient's personal property;
- patient abandonment;
- directly influencing a patient to change his will;

- misappropriating drugs or other property belonging to a member's employer;
- participating in advertising or endorsing a product;
- failure to inform the member's employer of the member's inability to accept specific responsibility in areas where special training is required or where the member does not feel competent to function without supervision;
- failure to report the incompetence of colleagues whose actions endanger the safety of the patient;
- failure to exercise discretion in respect of the disclosure of confidential information about a patient;
- falsifying a record in respect of the observation or treatment of a patient;
- practising while under the influence of alcoholic beverages, drugs, hallucinogens, narcotic or anaesthetic preparations or any substance which may cause intoxication, a diminuation or disorder of the faculties or unconsciousness;
- the fact of inducing someone to make use of his professional services;
- to enter false items in a client's record or to insert notes under another person's signature;
- to alter in the client's record notes already entered or to replace any part with intent to

falsify them;

- to communicate with the plaintiff whenever he is informed of an inquiry into his professional conduct or competence or whenever a complaint has been served against him;
- failure to comply with the code of ethics of the association;
- failure, without reasonable cause, to respond to enquiries from the association regarding alleged professional misconduct or professional incompetence;
- conspiring to do any misconduct or counselling a person to do any misconduct (Code of Ethics of Nurses, 1983, 4.01.01; Nova Scotia Registered Nurses' Association Act, Regulations, 1986, p. 552; Northwest Territories Nursing Profession Ordinance, 1975, s. 23; Ontario Health Disciplines Act, 1980, s. 21; Saskatchewan Registered Nurses' Association Bylaws, 1985, xv, s. 1)

The behaviours which are deemed to be "unbecoming to a registered nurse" are numerous. Philpott (1985) states:

> Conduct unbecoming to a nurse is not a closed category since what would amount to such professional misconduct would change over time as customs and mores change. It usually concerns conduct that is considered to reflect on the honor and integrity of the profession and is not necessarily directly related to nursing practise. (However, the Ontario regulations suggest that the conduct is tied to the performance of nursing services and is conduct which would reasonably be regarded by the profession as disgraceful, dishonourable or unprofessional.) The

> statute or the regulation usually provides for the publication of a Code of Nursing Ethics. The Code is perceived as binding on the profession and breaches of it would likely be dealt with under the category of professional misconduct. (p. 145)

In this study, the unacceptable nursing behaviours identified as being related to professional misconduct included the following:

- physical and verbal abuse of a patient, i.e., slapping an aggressive disabled patient and "tapping" a child who was misbehaving on the cheek;
- misappropriating drugs;
- failure to ensure the safe administration of medications (20 cases);
- failure to notify present employer that she had been dismissed from previous employment prior to the completion of the probationary period;
- failure to adhere to principles of disclosure of confidential information;
- failure to inform employer that she was working in one institution while on paid sick leave from another;
- failure to follow established policies and procedures in regards to nursing practise and patient care;
- failure to follow established policies and procedures in regards to documentation, i.e., falsification of records;

- failure to provide for the safety and well-being of patients;
- failure to collaborate with other members of the health care team;
- patient abandonment;
- failure to provide verification of an annual physical examination thus violating the agency's legislative requirements;
- failure to account for unauthorized absences from the unit and for tardiness;
- uttering two forged documents and committing perjury at a Registration Committee hearing;
- blackmail of a patient;
- practising under the influence of drugs or alcohol;
- failure to provide care in an intensive care unit because of a directive from the union;
- failure to have a physician's order prior to administering a medication;
- failure to account for medication listed in the Controlled Substance Administration Record which were in excess of the physician's orders; and
- criminal conviction, i.e., possession of marijuana for the purpose of trafficking.

In summary, the definition of professional misconduct appears to be open-ended. In some provinces, medication errors are considered to be indicative of incompetence while in other provinces, such as Ontario and Quebec, medication errors are classified under the broad heading of professional misconduct. In one case cited in Ontario, a nurse's Certificate of Competence was revoked on the grounds of professional misconduct and incompetence. One of the unacceptable nursing behaviours included "unprofessional language and demeanour." This situation was tested in the Supreme Court of Colorado and the judge concluded:

> If it was held to be the rule that profanity is a ground for revoking a license, then there would be a serious depletion in the ranks of all professions. (Cited in Mason v. Registered Nurses' Association of British Columbia, 1979, p. 18)

Therefore, the term professional misconduct must be considered in light of the definition in the respective professional legislation and in its usage in precedent setting cases. Unprofessional language in itself apparently is not sufficient grounds for suspension or revocation of license but must be considered with other unacceptable behaviours.

There are two other terms worthy of explanation since behaviours associated with these terms have resulted in suspension from employment, dismissal from employment, and suspension of license for a specified time period. The terms are "neglect of duty" and "insubordination."

In this study, the term "neglect of duty" is defined as a failure to perform duties in accordance with established policies, rules and regulations. The unacceptable nursing behaviour associated with this term is sleeping on the job. The term "insubordination" refers to a refusal to obey an order from administration. The unacceptable nursing behaviours associated with this term include:

- failure to follow a directive from management to float to a unit where a spouse was the director;
- failure to accept care for a critically ill patient;
- failure to follow direct orders by management to care for a patient;
- failure to follow established policies and procedures in regards to appointing a nurse-in-charge during the shift;
- failure to report circumstances of an incident to management involving refusal to care for a patient.

In situations where nurses have refused to obey directives from management, a suspension from employment for a specified period has been the disciplinary action imposed. Arbitrators use the term "obey now, grieve later" to indicate that in situations where a direct order has been issued by management, it is in the best interests of the employee to obey and then file a grievance as set out in the collective agreement.

Conclusion

In this chapter, the investigator has provided an analysis of the findings based upon the sub-problems of this study. In sub-problems 1-3, the investigator first reviewed the problem. This was followed by a summary of the Canadian cases examined in each category. The unacceptable nursing behaviours identified from the cases were then reviewed.

Following the review, operational definitions were presented for negligence, incompetence, unskilled practise, and improper conduct or professional misconduct based upon legal definitions and definitions cited in arbitration cases and professional legislation. Included in the definition was a list of unacceptable nursing behaviours identified from the cases.

Chapter 8

SUMMARY, CONCLUSIONS AND IMPLICATIONS OF THE STUDY

Problem and Procedures of the Study

Problem and Sub-Problems

The major problem of this study was to define unacceptable nursing practise in public hospitals using examples from case law, arbitration cases, and professional discipline cases as these relate to disciplinary action against nurses in Canada. The sub-problems of this study were:

1. To determine the types of nurse behaviours which resulted in negligence lawsuits and the legal consequences of these behaviours.

2. To determine from arbitration cases, the types of nurse behaviours which resulted in suspension or termination from employment and the arbitral consequences of these behaviours.

3. To determine the types of nurse behaviours which resulted in disciplinary actions by the professional association.

4. To provide operational definitions of negligence, incompetence or unskilled practise, and professional misconduct based upon the findings of the study.

This study was delimited to legal cases involving negligence, arbitration cases resulting in suspension and termination of employment among registered nurses in public hospitals, and professional discipline cases resulting in license suspension and license revocation.

Limitations of the Study

The major limitations of the study were the following:

1. Access to professional discipline cases was limited since this information is not published in the majority of provinces or territories.

2. Access to unpublished labour arbitration cases was limited since data retrieval systems have not yet been universally implemented.

3. Access to published labour arbitration cases was limited since retrieval systems have not yet been established in all provinces and the territories and arbitrators are under no obligation to file these cases.

In total, 107 cases were examined and incorporated into the study of which 24 were legal cases, 40 were arbitration cases, and 43 were professional discipline cases. Professional associations from across Canada provided a number of cases for examination, and offered the investigator an opportunity to conduct an in-depth study of the cases. Because of time and economic constraints, this was not feasible.

Literature Review

A review of the literature on professionalism and on competency in nursing practise was prepared in order to provide background information related to the study (Chapter 2). Based on this literature review, nursing was found to be a semi-profession since this field has yet to develop a unique body of knowledge and since nurses do not have the autonomy of practitioners in the profession. Nurses are currently developing a systematic body of knowledge, unique to nursing, professional authority, and codes of ethics. Nursing has a long established history of community sanctions and establishment of a professional culture. Several scholars concluded that nursing can achieve the status of a profession if nurses are prepared to present a unified approach to the complex problems confronting the field such as entry to practise, autonomy for practitioners, role clarification, competency issues, discipline, and the conflicting demands of professionalism and unionism. Of importance is the need for nurses to create an awareness of exactly what it is that they do. In addition, it was found that nurses, because of their legal, employee and professional responsibilities, may be subject to civil lawsuits, grievance arbitration and professional discipline. As the professional status of nursing increases, nurses may be subject only to the courts and professional discipline as is the case for other professions, or they may attempt to retain the grievance arbitration process in a modified form. It is suggested that the grievance arbitration process take into consideration professional concerns. For example, if a nurse is dismissed as a result of medication errors, and has been referred to the professional association, then the professional association should hear the case first and the findings should be presented at the arbitration hearing.

In terms of competency, the literature review revealed no valid or reliable tests for measuring competency in nursing practise. Scholars in this field suggest that educators and administrators should jointly develop a philosophy on "what constitutes training competent nurses" (Blanchard, 1983, p. 43) and further that skills lists in the cognitive, affective and psychomotor domain need to be expanded and validated.

Methodology

The methodology most suited to a study involving the review of cases of unacceptable nursing practice was content analysis. The major sources of data included: published and unpublished arbitration case documents, legal case documents, published and unpublished professional discipline case documents, and interviews. In order to analyze the cases in a logical sequence a schematic presentation was developed for classifying unacceptable nurse behaviours identified in the legal, arbitral and professional discipline cases.

To attest to the validity and reliability of the study, an "audit trail" was established in order that an external auditor could examine the case summaries and verify their accuracy. In addition, specific sections of this study were forwarded to experts in legal, arbitral and professional discipline matters to attest to the validity and reliability of the findings.

Findings of the Study

Legal Cases

In order to provide background information for the reader, a general overview of the Canadian legal system was presented. The literature incorporating specific concerns to nurses, such as standard of care, documentation, and failure to provide adequate staff coverage, was examined and where appropriate specific case examples were cited. Since one purpose of the study was to determine the types of nurse behaviours which resulted in negligence lawsuits, specific cases relating to civil lawsuits and negligence, civil lawsuits and dismissal cases, and a criminal lawsuit and public inquiry into the deaths of infants at Sick Children's Hospital in Toronto were reviewed. The civil lawsuits involving negligence were further categorized into those that were patient related, those that were medication related, and those that were procedure related. A total of 24 legal cases were examined. The breakdown of these cases was as follows: patient related (6), medication related (6), procedure related (9), dismissal cases (2), criminal lawsuit and public inquiry (1). The major point evident in the legal cases was that nurses are responsible for their actions because of the serious, often life or death consequences of their behaviours.

Arbitration Cases

The analysis of the arbitration cases identified types of nurse behaviours which resulted in suspension or termination from employment and the arbitral consequences of these behaviours. Historical underpinnings of dismissal for "just cause" were presented followed by a general overview of grievance arbitration in order to provide background information on this process. General considerations in regards to arbitration cases focused upon the prior record of the employee, the culminating incident, organizational policies and regulations, the use of progressive discipline, the distinction between probationary and other employees, and the concept of "quit or be discharged." This was followed by a review of selected Canadian arbitration cases which resulted in the suspension and termination from employment of nurses. In total, 40 such cases were analyzed. The breakdown was as follows: general incompetence (5), medication errors (7), insubordination (4), neglect of duty (2), professional misconduct (7), excessive absenteeism (10), alcohol or drug related (1), dismissal on religious grounds (1), miscellaneous (2), and inarbitrable (1). The major finding from the review of arbitration cases was that nurses are being held increasingly responsible for their actions in the employment settings. As cited in one of the cases analyzed, arbitrators have taken the view that an employer is:

> . . . entitled to expect a higher standard of conduct, in so far as it relates to professional competence, from a professional person such as a registered nurse, than an employer in industry is entitled to expect from the average rank and file employee. (Hospital Montfort and Ontario Nurses' Association, 1975, cited in Oshawa General Hospital and Ontario Nurses' Association, 1976, pp. 188-189)

The disciplinary actions imposed by the employer and upheld by arbitrators varied according to the arbitrator and the province or territory in which the arbitration hearing was held. For example, in one province a nurse was dismissed for a medication error even though the professional association also reviewed the case and felt that the nurse had done what was "reasonable and prudent" (Midale Hospital and Saskatchewan Union of Nurses, 1986). In a similar situation in another province, the nurse administered the wrong medication to the patient and was reinstated to her position following a six month suspension of her license by the professional association

(Owen Sound General Hospital and Marine Hospital and Ontario Nurses' Association, 1977b). In addition, it was found that the terms negligent and incompetent are frequently interchanged and often misused.

Professional Discipline Cases

The third major focus for the study was on the types of nurse behaviours which resulted in disciplinary action by the professional association. The legislation governing professional discipline was first examined. This was followed by a review of selected professional discipline cases during the period 1973-1986. In total, 43 discipline cases of three main types were examined: incompetence (3), professional misconduct (37), and those involving both professional misconduct and incompetence (3). The disciplinary actions imposed in these particular cases included: revocation of license (10), suspension of license (16), reprimand (10), restriction of practise (4), counselling (1), and miscellaneous (18). It should be noted that in several cases, two or more disciplinary actions were imposed. It was found that:

1. procedures in regards to the manner in which professional discipline was handled varied across the various provinces and territories, i.e., the process of complaints investigation and the appeal procedures followed;

2. the definitions of incompetence (unskilled practise), improper conduct or professional misconduct differed across the various provincial and territorial jurisdictions in Canada;[2]

3. there appeared to be inconsistencies in the types of disciplinary action imposed across the nation.

An analysis of the three sets of major findings led to the identification of categories of unacceptable nursing behaviours. Operational definitions for negligence, incompetence or unskilled practise, improper conduct or professional misconduct were developed.

Operational Definitions

Operational definitions of negligence, incompetence, and professional misconduct were developed based upon legal definitions, definitions cited in arbitration cases, professional legislation, and unacceptable nursing behaviours identified in this study. It will be apparent to the reader that some of the descriptors listed in each definition may be specific to the field of nursing; others may apply more generally to human service occupations such as medicine, dentistry, pharmacy, physiotherapy, social work and teaching as well as nursing; still others may apply to careers in general including engineers, architects, pilots, employee occupations (particularly those that are unionized or whose members bargain collectively), carpenters, clerical workers, hockey players, and unskilled workers. Depending on the definitions which have been legislated in various jurisdictions in Canada, nursing and other human service occupations may be subject to the behaviors associated with negligence, incompetence and professional misconduct and specific behaviours associated with these definitions.

Negligence. The definition cited in the legal case Blythe v. Birmingham (1856) is still being used today:

> . . . the omission to do something which a reasonable and prudent man guided upon those considerations which ordinarily regulate the conduct of human affairs would do, or doing something which a reasonable or prudent man would not do. (p. 784)

Herbert (cited in Prosser, 1955) elaborates on the concept of the "reasonable man" as follows:

> He is an ideal, a standard, the embodiment of all those qualities which we demand of a good citizen . . . . He is one who invariably looks where he is going, and is careful to examine the immediate foreground before he executes a leap or bound; who neither stargazes nor is lost in meditation when approaching trap doors or the margin of a dock; . . . who never mounts a moving omnibus and does not alight from any car while the train is in motion . . . and will inform himself of the history and habits of a dog before administering a caress; . . . who never drives his ball until those in front of him have definitely vacated the putting green which is his own objective; who never from one year's end to another makes an excessive demand upon his wife, his neighbors, his servants, his ox, or his ass; . . . who never swears, gambles or loses his temper; who uses nothing except in moderation, and even while he flogs his child is mediating only on the golden mean . . . . In all the mass of authorities which bears upon this branch of the law there is no single mention of a reasonable woman. (p. 125)

In the legal, arbitral and professional discipline cases that were examined by the investigator it was found that nurses are expected to have a higher standard of conduct than other skilled or semi-skilled employees in the work force. They were expected to behave as a "professional" and thus they were expected to perform in a manner which encompassed meeting a certain "standard of care." This "standard of care" was taught to them either in their basic training or had been established by the professional association in the standard of nursing practise and the code of ethics. "Expert" witnesses in nursing testified in the court cases described in this study, whether or not the nurse had met the standard of care that was expected.

The nursing behaviours that define negligence include failure to:

- provide an established standard of care,
- assess the patient at regular intervals and to report any untoward changes to the attending physician,
- document patient care according to established practises,
- administer medications according to established policies and procedures,
- follow established procedures and provide for the safety of patients.

Incompetence or unskilled practise. In its broadest definition, incompetence is defined as ". . . a lack of knowledge, skill or judgement or disregard for the welfare of a patient" (Health Disciplines Act, 1980, s. 83[5]). The terms incompetence and negligence have been interchanged by lawyers and labour experts, however, the terms are not synonymous. As cited in Mason v. Registered Nurses' Association of British Columbia (1979), "A competent nurse may sometimes be negligent without being incompetent, however, habitual negligence may amount to incompetence" (p. 24).

The nursing behaviours that define incompetence include failure to:

- demonstrate knowledge, skill, or judgement in medication, intravenous or blood administration,
- follow established policies and procedures for provision of patient care,
- follow physicians' orders,
- perform a nursing assessment and plan of care,
- provide for the patient's safety,
- follow established policies and procedures in regards to documentation,
- fulfill responsibilities to assigned patients,
- communicate changes in patient's condition to the attending physician or members of the health care team.

In addition to the above noted behaviours, a nurse may be deemed to be incompetent for failing to upgrade knowledge or provide a plan to improve skills or to acknowledge the importance of errors, and for failing to request assistance from colleagues if unsure of a particular practise or when unable to cope with a situation.

Improper conduct or professional misconduct. The term professional misconduct or improper conduct refers to "conduct unbecoming to a registered nurse." It is important that nurses consult the definition within their provincial or territorial jurisdiction for the behaviours deemed inappropriate since definitions vary from province to province.

The nursing behaviours that define professional misconduct include:

- physical or verbal patient abuse,
- misappropriating a patient's personal property,
- misappropriating drugs or other property belonging to an employer,
- practising while under the influence of alcohol, drugs, hallucinogens, narcotic or anaesthetic preparations,
- fraud,
- forgery,
- criminal conviction,
- disclosure of confidential information,
- patient abandonment,
- blackmail of a patient,

- falsification of records,
- participating in advertising or endorsing a product,
- directly influencing a patient to change his will.

In some provinces, failure to follow established policies and procedures in regards to nursing practise and patient care is considered to be unacceptable nursing behaviour associated with professional misconduct. The province of Saskatchewan also includes the following behaviours as falling within the definition of professional misconduct:

> (g) . . . failed to inform a member's employer of the nurse's/nursing assistant's inability to accept specific training in areas where special training is required or while the member does not feel competent to function without supervision;
> (h) failed to report the incompetencies of colleagues whose actions endanger the safety of the patient; . . .
> (k) failed to comply with the code of ethics of the association;
> (l) failed without reasonable cause to respond to enquiries from the association regarding alleged professional misconduct or professional incompetence;
> (m) conspired to do any misconduct or counselled a person to do any misconduct. (Saskatchewan Registered Nurses' Association Bylaws, 1985, xv, s. 1)

In this section of the chapter, operational definitions for negligence, incompetence and professional misconduct were reviewed. As stated previously, it is apparent that some of the descriptors listed in each definition may be specific to the field of nursing; others may apply more generally to human service occupations such as medicine, dentistry, pharmacy, physiotherapy, social work and teaching as well as nursing; still others may apply to careers in general. It was found that definitions in various provincial jurisdictions varied depending on the relevant legislation. Nursing and other human service occupations may be subject to negligence, incompetence and professional misconduct and specific behaviours associated with these definitions. The behaviours which relate generally to nursing and to certain other health care occupations include: standard of practise, documentation of patient care, patient safety, communication with other professionals, and behaviours related with professional misconduct such as patient abuse, theft of drugs, forgery, fraud, practising while under the influence of drugs or alcohol, falsification of records and disclosure of confidential information. Behaviours such as criminal charges as they relate to the individual's ability to carry out his tasks, alcohol and drug abuse, physical and mental incapacity and absenteeism for health or other reasons may apply to careers in general, rather than specifically to the field of nursing or the health care occupations. It is important to remember that these descriptors may change as procedures, policies and technological changes occur. For example, at one time hot water bottles were placed in the patients' beds in order to combat shock following surgery.

This procedure is no longer used and has been replaced by warming the blankets placed on patients. This is only one example of the changes which have occurred in the practise of nursing with technological advances. It is anticipated that in the future technological changes will continue to increase and this will have an effect on the standards of practise and patient care.

A summary of the findings of the study will be presented in the following section.

Summary of the Findings of the Study

1. Nurses are facing lawsuits for: (a) failure to provide an established standard of care; (b) failure to administer medications following established hospital policies and procedures; (c) failure to carry out a procedure according to established hospital policies and procedures; (d) failure to document the patient's record in an appropriate manner; and (e) failure to ensure that the unit has adequate staff coverage prior to leaving for a break.

2. There appear to be discrepancies in the awards handed down by arbitrators, especially in regards to professional issues, i.e., medication errors.

3. The terms negligence, incompetence and misconduct have been frequently interchanged and often misused by arbitrators.

4. The disciplinary process of the professional

association varied in the provinces and territories in regards to the complaint procedure, the investigation procedure, and the appeal procedure.

5. The definitions for incompetence (unskilled practise), improper conduct or professional misconduct were used differently in various provinces and the territories.

6. There appear to be discrepancies in the types of professional disciplinary action imposed in various provinces and the territories.

Conclusions of the Study

1. Nurses are being held increasingly accountable for their actions by judges, arbitrators, the professional association and the public.

2. There appear to be changes in the types of lawsuits. Prior to 1940, the lawsuits were related to procedures, in particular, burns from hot water bottles. Nurses in the 1980's are facing lawsuits for their assessment and observation skills, for medication errors, for failing to document in an appropriate manner, and for leaving the unit without ensuring proper staff coverage.

3. The nurse of the 80's requires acute assessment and observational skills, a high knowledge skill base in regards to medications and their effects, and the ability to document patient care with diligence. It was suggested that nurses should not carry out a procedure for which

they have not received educational training or practise unless they are under the direct supervision of a clinical supervisor or instructor who is familiar with the procedure.

4. There appears to be a need for the development of standardized definitions of negligence, incompetence, and professional misconduct by the professional associations in order that these terms may be consistently applied in legal, arbitral, and professional discipline hearings.

5. There appears to be a need for nurse administrators to develop standardized procedures in order to provide staff members experiencing problems with guidelines to improve their performance, and an opportunity to attend educational programs designed to enhance their performance.

Implications of the Study

The study has a great number of potential implications. These fall in several categories as follows:

implications for employers;
implications for arbitrators;
implications for professional associations and nursing unions;
implications for practising nurses;
implications for nurse administrators;
implications for nurse educators;

implications for further theoretical advances; and implications for further research.

Implications for Employers

Nurses typically are employees of public hospitals, government agencies and private agencies and thus the employer in most instances is held to be liable for their actions. Since this is so, the following implications are presented for consideration by employers:

1. That standardized policies and procedures be developed utilizing the framework established by professional nursing associations in their statements of standards of nursing practise and code of ethics.

2. That organizational rules and regulations clearly outline the rules that a nurse is expected to follow and that this information be included in the policy and procedure book and be conveyed to the new employee at the time of orientation, e.g., policy in regards to sleeping on "unpaid" breaks.

3. That employers provide paid ongoing opportunities for nurses to attend inservice training in the hospital, or workshops presented by other organizations (universities, colleges, professional associations) in order that nurses may keep abreast of the changes in patient care and technological advances.

4. That inservice workshops be held on an ongoing basis in regards to medication administration and

documentation of patient care.

5. That nursing union and management meetings be established and address the issues which are of concern to practising nurses and the employers. The areas of concern, albeit not inclusive include: staffing ratios, workload indices, "floating" a nurse to areas where she has not received previous training, infection control (e.g., exposure to AIDS), exposure to elements in the environment that could be hazardous to the employee's health (e.g., gases in the operating room, x-rays, and chemotherapeutic agents).

6. That nurse managers receive educational programs in contract interpretation and discipline procedures. It is suggested that standardized procedures be developed for disciplining members in regards to alcohol and drug abuse, medication errors, incompetence, and other areas deemed to be of concern to practising nurses, their professional association and their union.

7. That employees experiencing difficulties be provided an opportunity to attend educational programs or counselling. It is suggested that employers evaluate the effectiveness and efficiency of their own employee assistance programs and consider alternatives such as referral to private practitioners (e.g., psychologists, psychiatrists) since several employees have viewed as threatening, the employee assistance program at their workplace.

8. That employers ensure that employees are treated in a fair and consistent manner in regards to discipline. For example, one employee is given a three month suspension for a medication error while another employee is given a three day suspension.

9. That hospital associations (as representatives of employers) in each province consider the formation of a liaison body with representatives from professional associations, arbitrators, and judges in order to address the structure and process of the discipline of members of professional and semi-professional bodies.

Implications for Arbitrators

The process of collective bargaining and the grievance arbitration process by professionals is a fairly recent phenomenon. It is only in the last two decades that professionals have formed bargaining units and utilized the grievance arbitration process to voice their concerns. Today, arbitrators are being requested to make judgements on dismissals concerning professional issues, medication errors, incompetence, and professional misconduct. The following implications are presented for consideration by arbitrators.

1. That educational programs for arbitrators include relevant information or case studies concerning professional issues. It is suggested that various professional associations present the standards of

practise relevant to their particular membership.

2. That a forum be developed with professional associations and legal experts to consider alternative avenues for discipline of professionals. For example, one alternative is to allow or require the professional association to be present at the arbitration hearings either to summarize the findings of the professional discipline committee hearing or to present expert testimony in regards to established standards of practise. Another alternative may be to develop a forum whereby there is representation from the employer, the union, and the professional association.

Implications for Professional Associations and Nursing Unions

Since the process of professional discipline has become highly complex, the following implications are presented for consideration by the professional nursing associations and nursing unions.

1. That a forum be held by professional associations of nurses across Canada to facilitate the establishment of standardized definitions for incompetence and professional misconduct of nurses and standardized procedures for the discipline of nurses.

2. That a standardized reporting mechanism for collecting data in regards to the types of cases heard and the disciplinary actions imposed be developed by the professional association and the nursing union to

facilitate the sharing of information with other provinces and territories.

3. That a computerized data base be established by the professional association and the union with pertinent information on type of case, charges against the nurse, significant factors presented during the hearing, and disciplinary action imposed so that up-to-date information is available when future cases are heard.

4. That a list of experts in each specialty area be compiled in each province and territory in order that expert opinion is presented during legal, arbitral, or professional hearing.

5. That the professional discipline committee structure be modified or a "revolving" committee structure be considered when examining cases which involve a particular specialty area, e.g., intensive care. It is suggested that professional associations address the question of whether the committee structure as it stands would "stand up under the scrutiny of the Charter of Rights." In other words, could the professional discipline procedure explicitly state that the individual was being judged by impartial peers with knowledge and skills in the area being assessed?

6. That professional associations and unions representing professionals liaise with arbitrators and legal experts to consider alternative avenues for the discipline of professionals such as presenting expert

testimony during the arbitration hearing or by inclusion of a member of the professional association in the arbitration panel.

7. That the recommendations of the professional discipline committee be presented during the arbitral hearing.

8. That professional associations consider whether discipline cases should be heard in camera or be open to the public either by publishing names of those individuals who have been disciplined, along with the charges and outcomes of the discipline procedures or by making all discipline hearings public.

9. That research money be made available in each province and the territory for extending the research on the arbitral and professional discipline cases and for developing competency standards.

10. That unions bargain on behalf of their membership for paid inservice and educational allowances in order that members may keep current in their areas of specialty.

Implications for Practising Nurses

1. That each nurse develop a broad knowledge-skill base in her or his particular specialty area.

2. That nurses continually strive to update the skills and practises relevant to their field of practise.

3. That nurses be aware of their legal, employment and professional responsibilities. One way of doing this is by attending courses relevant to these areas.

4. That nurses become and continue to be knowledgeable regarding their professional Standards of Practise, Code of Ethics, professional legislation and the definitions of incompetence and professional misconduct which have been developed by the professional association in their particular jurisdiction.

5. That nurses become knowledgeable about the roles and responsibilities of the professional association (and College of Nurses in Ontario) and of the nursing union in their jurisdiction.

6. That nurses become aware of policies, procedures, rules and regulations governing the setting in which they are employed. If they are requested to carry out a procedure for which they have not received previous education or training, this should be communicated to the clinical supervisor or charge nurse. If there are no policies or procedures for the task to be performed, all relevant information should be documented and a disclaimer form filed by the nurse indicating that she or he has not performed this task before and has not received training to do so (e.g., being requested to perform peritoneal dialysis on an infant when no training has been received in this technique and when there are no policies and procedures to follow as guidelines.) Rozovsky (1974)

cautions health care workers to "refuse to carry out any task for which you have not been trained" (p. 53). If one is informed that one must carry out the task one should ensure that it is done in the presence of a clinical supervisor or charge nurse.

7. That a nurse ensure policies and procedures are followed especially in regards to the administration of medications. One of the steps which was consistently identified in the review of unacceptable nursing practises was failure to check the identification bracelet against the medication card.

8. That where a physician directs that an order be carried out that in the judgement of the nurse involved is not a correct order, then it is the responsibility of the nurse to inform the physician. If the physician refuses to modify or carry out the order it is the responsibility of the nurse to notify the supervisor. If the nurse feels that the supervisor has not remedied the situation in a reasonable manner then she or he may refuse to carry out the order. An incident report should be filed immediately detailing the situation.

9. That where a nurse has any doubts regarding a physician's order (e.g., unable to make out the amount of drug to be given), the order should first be clarified.

10. That nurses file incident reports on physical injuries such as accidental falls, medication errors, drug reactions, and unexpected changes in the patient's

condition. This should be done even if there are doubts about a situation but the possibility exists of repercussions.

11. That nurses ensure the patient's condition is documented with care and diligence. Arbitrators have held the view that if "nothing is charted, one can assume that nothing was done." The documentation should be accurate, detailed and include times when treatments and procedures were carried out.

12. That nurses develop a knowledge base in labour relations and collective bargaining. It is further suggested that some nurses consider developing their expertise in arbitration so they would be available to arbitrate those cases involving the discipline of nurses.

Implications for Nursing Administrators

In this study nurse administrators were found to be accountable for the standards of care provided by the staff under their supervision. Arbitrators have frequently criticized nurse administrators for their failure to provide members of staff with guidelines to improve their performance, failure to design educational programs to enhance the employee's performance, failure to utilize progressive discipline, failure to extensively document the problem, and failure to ensure that the employer was aware of the problem. In Table 8.1, a summary of professional issues and suggested processes is

Table 8.1

A Summary of Professional Issues and Suggested Processes for Discipline of Employees for Nurse Administrators

Reason	Discussion	Suggested Processes
Absenteeism	Based upon findings from this study, arbitrators have held the view that employers should analyze not only the numbers of days the employee was absent but also the reason for the absence.	1. Documentation should be kept on all employee absences and reasons for same. In addition, patterns need to be monitored, e.g., weekends, an extra day prior to or following a weekend. 2. Employer has the right to request a medical certificate if absence longer than three days (check collective agreements). 3. If absence is a result of alcoholism, drug abuse, personal problems or stress related, the employer may offer a period of rehabilitation or request that the employee attend an Employee Assistance Program. 4. Progressive discipline.
Alcoholism	Arbitrators and judges view that alcoholism is not in itself sufficient grounds for dismissal. The actions of the employee in terms of his performance must be of such a nature	1. All work-related behaviour associated with the employee's ability to perform his duties should be carefully documented. 2. Offer the employee an opportunity for

Table 8.1 (Continued)

Reason	Discussion	Suggested Processes
	that it warrants termination of the employment relationship or can be justified.	rehabilitation. 3. Utilize progressive discipline. Inform the employee that his behaviour is affecting his work and offer a reasonable time for improvement.
Criminal Conviction	An employee who is convicted "of a criminal offense which jeopardizes the employer's property and security, its public reputation, or the interests of other employees may be disciplined" (Brown & Beatty, 1983, p. 399). In most instances the employee may be suspended pending trial. In the case cited in this study, arbitrators took the view that the criminal conviction was unrelated to the individual's ability to perform the tasks required. The employer was also unable to prove that the nurse had forfeited public trust and confidence (Oshawa General Hospital and Ontario Nurses' Association, 1981).	1. It is suggested that the case be assessed on whether the employee has been convicted of an offense which would destroy the public's trust or confidence. 2. Where no conviction has occurred, the employee may suspend the employee until an investigation has been completed or a trial held.

Table 8.1 (Continued)

Reason	Discussion	Suggested Processes
Discrimination	Employers may not discriminate on the grounds of: - age - alcoholism - colour - creed - drug dependance - family status - mental disability - nationality - pardoned offense (not related to the employee's ability to perform his job) - physical disability - political belief - pregnancy - race - religion - sex - sexual orientation. ("Employment Law Rapid Reference Guide," 1983, p. 59)	1. From the findings of this study, it is suggested that documentation be kept on all complaints received by management. 2. Each complaint should be investigated and actions taken where warranted. 3. Employers may wish to set up clear guidelines for staff in regards to discipline that may occur if other employees' rights have been violated.
Dishonesty (Fraud)	Fraud and dishonesty are considered as justification for dismissal. Arbitrators have held the view that it is important to consider the reasons for the dishonesty.	1. Documentation should be kept on all discussions with the employee and other evidence given by employees. 2. Depending upon the circumstances of the case, the employee may be suspended pending further investigation and subsequently dismissed or dismissed immediately. (Note: An employer dismissing an

Table 8.1 (Continued)

Reason	Discussion	Suggested Processes
		employee for fraud or dishonesty may have to prove the case on whether the employee employer relationship can no longer continue because of a lack of trust.)
Incompetence	"Boards of arbitration have consistently affirmed management's right . . . to discipline employees who are careless or negligent in the performance of their work, who disregard safety procedures or who generally exhibit poor work habits" (cited in Brown & Beatty, 1984, p. 411).	Based upon findings from this study it is suggested: 1. Employers carefully document all behaviour which falls below the accepted standard. The employee should be informed of the incident immediately and written documentation of the incident and verbal discussion should be kept. 2. The employer may hold a meeting with the employee and establish written guidelines as to how the deficiency may be corrected and when a re-evaluation will take place. 3. The employer offer the employee an opportunity to partake in courses and educational programs designed to assist the individual to improve performance standards.

Table 8.1 (Continued)

Reason	Discussion	Suggested Processes
		4. The employer utilize progressive discipline. 5. The employer utilize performance appraisals as a method of communicating areas in which the individual should improve.
Professional Misconduct	The behaviours associated with professional misconduct vary from province to province, therefore employers should consult their respective professional legislation. Depending upon the circumstances of the case, employers may report the misconduct to the professional association in addition to imposing disciplinary action. If the misconduct involves abuse, theft, or misappropriation of drugs, the employer may suspend the employee prior to the completion of an investigation and subsequently dismiss or dismiss immediately.	1. It is suggested that an investigation be conducted into the specific details of the conduct. Based upon the findings of this study, arbitrators and professional associations require detailed documentation. 2. The employer should discuss the circumstances with the employee and document in detail what was stated by both the employee and the employer. 3. The employer may suspend the employee prior to an investigation and subsequently dismiss the employee or dismiss immediately, depending on the circumstances.

presented for consideration by nurse administrators. The summary is relevant not only to nurse administrators but also to practising nurses since it provides nurses with an opportunity for educational programs and rehabilitation programs designed to enhance their performance prior to discipline being imposed. The issues which have been given particular attention include: absenteeism, alcoholism, criminal conviction, discrimination, dishonesty (fraud), incompetence, and professional misconduct.

The following implications and suggestions are presented for consideration by nursing administrators:

1. That a strong knowledge-skill base form the foundation for labour relations matters, the collective bargaining process, the grievance arbitration process, and the use of progressive discipline.

2. That administrators be knowledgeable in regards to the policies, procedures, rules and regulations affecting their particular setting.

3. That administrators be knowledgeable about the clauses in the collective agreement which affect the employment setting. Contract interpretation is a complex process so it may be advisable to check with the personnel department or in some cases legal counsel in regards to the correct interpretation.

4. That administrators develop guidelines to assist those nurses who have performance problems, i.e., the area

which is of concern, when the problem is to be resolved, and how it will be resolved. Arbitrators have stressed the importance of documentation, ensuring that employees are aware of the problem and providing the employee with every opportunity to improve. Educational programs that enhance the individual's performance have been suggested by judges, arbitrators, professional association and scholars.

5. That nurse administrators provide medication seminars to staff on a regular basis, as suggested by several arbitrators in order that staff are aware of the appropriate policies and procedures.

6. That nurse administrators consider the feasibility of collaborating with nurse educators to develop nurse competency skill lists for nurses with emphasis on the psychomotor domain, as suggested by several scholars.

Implications for Nurse Educators

In this study, it was found that a nurse educator was dismissed from employment for failure to ensure that student nurses under her supervision followed established policies and procedures in regards to medication administration (Humber College of Applied Arts and Technology and Ontario Public Service Employees' Union, 1976). Goclowski (1985) also cautions educators that they may be held liable for a student's performance:

> Nursing faculty may be caught in an interesting "catch-22" phenomenon. There exists a possibility where an educator may be sued for both failing, and not failing a student. An incompetent graduate may sue for inadequate education, and a dismissed student may sue the faculty member for failing to treat the student in a logical and reasonable manner. (p. 104)

The following implications are presented for consideration by nurse educators:

1. That nurse educators be knowledgeable and competent in regards to their area of expertise and constantly strive to update theoretical and practical skills.

2. That nurse educators develop a knowledge-skill base in labour relations and in particular the grievance arbitration procedure for purposes of communicating this information to student nurses.

3. That nurse educators consider the development of courses which outline legal, employment and professional responsibilities of nurses.

4. That in the event a student nurse has a particular problem the nurse educator should ensure that all discussions are accurately documented.

5. That nurse educators consider establishing guidelines for those student nurses experiencing problems.

6. That nurse educators consider the feasibility of collaborating with nurse administrators to develop nurse competency skill lists with emphasis on the psychomotor domain, as suggested by several scholars.

Implications for Further Theorizing in This Area

Dunlop's theoretical model which formed the theoretical framework for the study was adapted by including the concepts of professional environment, professional discipline and professional issues. In this study, it was found that nurses along with professionals and semi-professionals generally are held more accountable and responsible for their actions than other employees by judges, arbitrators, other professionals and the public. This study is applicable to other professionals and semi-professionals such as physicians, teachers, pharmacists, engineers, occupational therapists, and physiotherapists since many of the legal, arbitral and professional discipline cases are relevant. These occupational fields could replicate this study in their particular field to further enhance the classification scheme developed for assessing unacceptable behaviours and developing definitions for incompetence and professional misconduct.

It was also noted that in the field of nursing legal, economic, political, socio-cultural and professional factors have an impact on working conditions, industrial conflict, wages and fringe benefits, turnover, absenteeism, productivity, attitudes and professional issues. Other professionals and semi-professionals could further assess the impact these factors have on their discipline.

Organizational theorists may further enhance the concepts of professional environment, professional discipline and professional issues in their theoretical models which depict professionals in bureaucracies.

Implications for Further Research

It is suggested that the following areas be considered for further research:

1. A study designed to examine the professional discipline cases in each province. The investigator was offered the opportunity to conduct this type of study in several of the provinces, however because of time and economic restraints it was not feasible at this time.

2. A comparative study of nurses and other professions in regards to legal, arbitral and professional discipline issues, e.g., social workers, pharmacists, engineers.

3. A study which examines the suspensions and terminations of employment among nurse managers in Canada.

4. A study which examines the suspensions and terminations of employment among nurse educators in Canada.

5. A study designed to examine the types of grievances filed by student nurses against nursing educators.

6. An in-depth scholarly review of competency in

nursing practise with particular emphasis on practising nurses, nursing students, nursing educators and nurse administrators.

7. A study designed to develop and evaluate a competency skill list which has been developed conjointly by nurse managers and educators.

8. A study designed to develop and evaluate a performance appraisal tool which focuses on the cognitive, affective and psychomotor skills of practising nurses.

9. A study which evaluates the effects of nurses being dismissed from employment, i.e., social, economic, legal and professional factors.

10. Studies designed to evaluate the effects of professionals, in general, being dismissed from employment, i.e., social, economic, legal and professional factors.

11. A study designed to evaluate the effects of environmental factors on medication errors, i.e., workload, size of medication room, "noise" in area while preparing medications.

12. A study designed to evaluate the standard for medication errors in nursing practise.

13. A study to evaluate the different types of methods of nursing care on medication administration, i.e., team versus primary care nursing.

14. A study designed to evaluate the protocol for medication administration in medication errors.

15. A study designed to further enhace Dunlop's theoretical model to include professional issues.

16. A study designed to enhance the incorporation of professional issues into organizational theories.

17. A study designed to examine the effects of firing on those who are responsible for performing the task.

18. A study designed to examine the impact of absenteeism on nursing practise, i.e., workload and stress of others on the unit.

19. A further development of a theory related to collective bargaining and nursing to incorporate professional issues.

20. A study designed to assess the impact of unionism and professionalism in nursing practise.

21. A study designed to evaluate how practising nurses view the role of the professional association and the union.

22. A study designed to evaluate the impact of the separation of the professional nursing association and the nursing union on practising nurses, nurse managers, and various organizations.

23. A study designed to evaluate the type of issues being dealt with at union-management meetings.

Concluding Comment

There is little doubt that tremendous changes have occurred in the field of nursing in the last decade. Technological advances, especially in regards to computerization, cost constraints in health services, an increase in the number of elderly persons being served, changes in the delivery of health care services to incorporate health promotion and self-care, and legislative and court challenge to nursing practise have certainly affected the practise of nursing. It is envisioned that such factors as privatization of health services, cost constraints in all types of health care settings, and public awareness will have an effect on the number and types of legal, arbitral and professional discipline cases in the future. The present study has as its altruistic purpose the improvement of nursing practise in Canada. Hopefully, the documentation of unacceptable nursing practises will provide a basis for improving nursing and protecting those who are in this field.

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APPENDICES

APPENDIX A

DEFINITIONS

Source:

Adapted from

Canadian Labour Congress. (1976). Glossary of terms. Ottawa: Author.

Sack, J., & E. Poskanzer, E. (1984). Labour law terms. Toronto: Lancaster House.

DEFINITIONS

ARBITRATION. A method of settling disputes through the intervention of a third party whose decision is final and binding. Such a third party may be either a single arbitrator or a board consisting of a chairman and one or more representatives. Arbitration is used to settle major grievances and/or for settling contract interpretation disputes.

Compulsory arbitration is that imposed by law. Governments impose it to avoid a strike or to end one.

ARBITRATION BOARD. A third party, composed of a chairman and one or two representatives chosen to hear a case or a group of cases which are submitted for arbitration.

BARGAINING UNIT. A group of workers employed in a craft, department, plant, firm, industry or occupation who are designated by the Labour Relations Board or similar body as appropriate for representation by a union for the purposes of collective bargaining.

The Labour Relations Board decides if the unit is appropriate by assessing several factors: history of collective bargaining; work performed; organization and representation of employees; employees' desires; commonality of interests among workers; and interchangeability of positions.

CASE LAW. Law based on previously decided cases rather than legislation (Sack & Poskanzer, 1984, p. 35).

CHECKOFF. A clause in a collective agreement authorizing an employee to deduct union dues and occasionally other assessments and transmit these funds to the union. Four types of checkoff include: (1) voluntary revocable; (2) voluntary irrevocable; (3) compulsory; and (4) Rand Formula--dues deducted from union and non-union employees.

CHECKOFF, COMPULSORY IRREVOCABLE. A clause in the collective agreement whereby the employer agrees to deduct the amount of the regular union fees from the pay cheques of those employees who are union members.

CHECKOFF, VOLUNTARY IRREVOCABLE. A clause in a collective agreement whereby the employer agrees to automatically deduct the amount of regular union dues from the pay cheques of those employees who have consented in writing to such a deduction. The check off is not revocable by any employee during the lifetime of the collective bargaining agreement.

CHECKOFF, VOLUNTARY REVOCABLE. This is a clause in the collective agreement whereby the employer agrees to deduct union fees provided the employee has consented in writing. These deductions will automatically be stopped when the employee withdraws his consent.

COLLECTIVE AGREEMENT. A written agreement between one or more unions acting as bargaining agent for employees, and one or more employers which contains provisions for wages, working conditions, fringe benefits, rights of workers and unions and procedures to be followed in settling disputes and grievances.

COLLECTIVE BARGAINING. A method of determining wages, hours and other work conditions through direct negotiations between the union and employer. Normally the result of collective bargaining is a written contract which covers all employees in the bargaining unit, both union and non-union members.

COLLECTIVE BARGAINING AGREEMENT. Terms and conditions of employment reached as the result of contract negotiations between an employer and the union representing his employees (may also be referred to as a 'union contract').

CONCILIATION AND MEDIATION. A process which attempts to resolve labour disputes by compromise or voluntary agreement. By contrast with arbitration, the mediator, conciliator or conciliation board does not bring in a binding award and the parties are free to accept or reject its recommendation. The conciliator is often a government official while the mediator is usually a private individual appointed as a last resort, sometimes even after the start of a strike.

COMPULSORY ARBITRATION. Arbitration imposed by law and is sometimes used by governments to avoid a strike or end one.

DISCHARGE FOR 'JUST CAUSE.' Discharge of an employer covered by a collective agreement which requires that just cause for discharge be established; where the employer fails to show just cause, compensation for lost wages and reinstatement to employment may be ordered by an arbitrator under the grievance and arbitration provisions of the collective agreement (Sack & Poskanzer, 1984, p. 53).

DISCIPLINE. Penalty imposed by an employer for alleged misconduct; ordinarily includes written warnings, reprimands, suspensions, and in some cases discharge, although discharge is often excluded from the definition of discipline and dealt with separately (Sack & Poskanzer, 1984, p. 53).

DRUG RELATED. Refers to a situation where a nurse has been involved in personal misuse or misappropriation of a drug.

GRIEVANCE. A claim or complaint involving the interpretation, application or alleged violation of a collective agreement; individual grievance: grievance relating to an individual employee; group grievance: grievance relating to a group of employees similarly affected by the employer's actions; policy grievance: grievance by a union which may involve a matter of general policy or of general application of the collective agreement (Sack & Poskanzer, 1984, p. 71).

IN CAMERA. Hearings held in private.

LABOUR RELATIONS BOARD. A board established under provincial or federal relations legislation to administer labour law, including certification of trade unions as bargaining agents, investigation of unfair labour practices and other functions prescribed under the legislation.

LOCAL (UNION). Also known as lodge, or branch. The basic unit of union organization. Trade unions are usually divided into a number of locals for the purposes of local administration. These locals have their own constitutions and elect their own officers; they are usually responsible for the negotiation and day-to-day administration of the collective agreements covering their members.

MEDICATION RELATED. Refers to a situation where a nurse has been responsible for the incorrect administration of a medication.

MITIGATING FACTORS. Circumstances that, while not completely excusing misconduct, tend to lessen the degree of guilt or reduce the extent of the penalty; in a discipline or discharge case, such factors include lack of intent, previous good record, long service, isolated nature of the incident, provocation, unpremeditated nature of the offense, special economic hardship, discriminatory treatment by the employer in failing to uniformly enforce rules, seriousness of the offense, apology by the grievor (Sack & Poskanzer, 1984, p. 99).

NEGLIGENCE. The omission to do something which a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable man would not do (Blythe v. Birmingham, 1856, p. 784).

OBEY NOW, GRIEVE LATER. An arbitral rule, requiring an employee to obey an employer's order, provided it is clearly communicated, and to test any question regarding the propriety of the order through the grievance and arbitration procedure; a violation of this rule may result in discipline for insubordination being held at arbitration, even though the order itself was not warranted; however, the rule has been held not to apply where substantial harm would result which could not be effectively remedied through the grievance and arbitration procedure, e.g., where the employer's order would endanger health and safety, or require the employee to perform an illegal act, or where obedience to the employer's order would interfere with the performance of urgent or important union business (Sack & Poskanzer, 1984, p. 107).

PROBATION. Initial period of employment during which the employer has an opportunity to assess the suitability of the employee (Sack & Poskanzer, 1984, p. 119).

QUALITY OF WORKING LIFE. A general term used to describe programs designed to improve the workplace environment or to increase worker participation in the production or decision-making process (Sack & Poskanzer, 1984, p. 123).

QUASI-JUDICIAL. A tribunal which is not required to follow the formal procedures of a court, but which is nonetheless akin to a court, and whose procedures must therefore be governed by the rules of natural justice (Sack & Poskanzer, 1984, p. 124).

RAND FORMULA. Also called Agency shop. A union security clause in a collective agreement stating that the employer agrees to deduct an amount equal to the union dues from all members of the bargaining unit, whether or not they are members of the union, for the duration of the collective agreement. See Checkoff.

RES IPSA LOQUITUR. A principle of evidence law according to which negligence may be inferred from the mere happening of an accident where, given the nature of the accident, it could not ordinarily have happened without negligence on the part of the alleged wrongdoer (Sack & Poskanzer, 1984, p. 131).

STRIKE. A cessation of work or a refusal to work or to continue work by employees in combination or in accordance with a common understanding for the purpose of compelling an employer to agree to terms or conditions of employment. Usually the last stage of collective bargaining when all other means have failed. Except in special cases strikes are legal when a collective agreement is not in force. A Rotating or Hit-and-run strike is a strike organized in such a way that only part of the employees stop work at any given time, each group taking its turn. A Sympathy strike is a strike by workers not directly involved in a labour dispute--an attempt to show labour solidarity and bring pressure on an employer in a labour dispute. A Wildcat strike is a strike violating the collective agreement and not authorized by the union.

SUSPENSION. To suspend a license is to interrupt, or cause to cease or to discontinue temporarily with the expectation of resumption, the practical result of which is to forbid the person from performing his duties for a more or less definite period (Philpott, 1985, p. 179).

TRADE UNION. Workers organized into a voluntary association, or union, to further their mutual interests with respect to wages, hours, working conditions and other matters of interest to the workers.

WORKING CONDITIONS. Conditions pertaining to the workers' job environment, such as hours of work, safety, paid holidays and vacations, rest period, free clothing or uniforms, possibilities of advancement, etc. Many of these are included in the collective agreement and subject to collective bargaining.

WRONGFUL DISMISSAL. A common law term used to refer to dismissal without cause of an employee contrary to the terms of his or her individual contract of employment (Sack & Poskanzer, 1984, p. 159).

APPENDIX B

SAMPLE OF LETTER FORWARDED TO PROVINCIAL NURSING ASSOCIATIONS

May 12, 1987

Dear _______________:

I am presently completing my doctoral dissertation titled, "Suspension and Termination of Employment Among Nurses in Canada." Enclosed please find a copy of the proposal.

The problem of the study is to define unacceptable nursing practice in public hospitals using examples of case law, arbitration cases, professional discipline cases and statute law as it relates to the suspension and termination of employment of nurses in Canada.

I was wondering if you could provide the following information:

1. The number of investigations which relate to professional discipline during the period 1973-1986.

2. The type of cases (i.e., incompetence, drug abuse, alcoholism) which were referred to the disciplinary committee or to the executive of the processional association and the action taken (i.e., counselling, suspension, revocation of licensure) for each year during the period 1973-1986. If you are able to provide specific information regarding any of the cases this would be appreciated. Anonymity of individuals will be assured.

3. A copy of the Nursing Practice Act and by-laws.

If you have any questions regarding the information requested please feel free to contact me at (403) 432-4909 (doctoral suite). It is anticipated that my dissertation will be completed in September 1987, and a copy will be forwarded to your association.

Thank you for your assistance in this endeavour.

Yours truly

Darlene Steven
Ph.D. Candidate

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APPENDIX C

A COMPARISON OF THE PRESENT REGISTERED NURSES' ACT OF BRITISH COLUMBIA WITH PROPOSED AMENDMENTS

A Comparison of the Present Registered Nurses Act of British Columbia with Proposed Amendments

Nurses (Registered) Act (as it Presently Exists)	Nurses (Registered) Act (with Proposed Amendments)	Explanatory Comments on Proposed Amendments
	Prohibition on employment or engagement 32. No person shall knowingly employ or continue to employ or engage, a person to engage in exclusive nursing practice if the person employed or engaged is prohibited from engaging in exclusive nursing practice by this Act.	Section 32 - Prohibition on Employment or Engagement This section is ancillary to the prohibition on unauthorized practice created by section 27.
	Prosecutions 33.(1) Any person may be prosecutor or or complainant under this Act, and the court may allot the penalties recovered or a portion thereof to payment of the costs of the prosecution. (2) The board of directors, with the Attorney General's consent, may by an order signed by the president of the association stay a prosecution under this Act.	Section 33 - Prosecutions This section will allow any person, including the association, to initiate prosecutions for offences under the Act. The board of directors, with the consent of the Attorney-General, will be able to prevent any prosecution from proceeding by ordering a stay under subsection (2).
	Injunctions 34. The association may bring an action in the Supreme Court for an injunction to restrain a person from committing a contravention of this Act and, pending final disposition of the action, may apply for an interlocutory or interim injunction.	Section 34 - Injunctions This section will allow the association to apply to court for an injunction restraining someone from committing a violation of the Act, e.g., to prevent an unauthorized person from engaging in the practice of nursing.
Discipline committee 22.(1) The board of directors shall appoint from among the members of the association a discipline committee consisting of the number of members determined by the board of directors.	Professional conduct committee 35.(1) The board of directors shall appoint from among the registered nurse members a professional conduct committee consisting of the number of members determined by the board of directors.	Section 35 - Professional Conduct Committee This section corresponds with section 22 of the present Act. The name of the "Discipline Committee" has been changed to

Nurses (Registered) Act (as it Presently Exists)	Nurses (Registered) Act (with Proposed Amendments)	Explanatory Comments on Proposed Amendments
(2) The discipline committee shall act in all its functions in panels of 3 members of the committee to be selected in the manner determined by the board of directors.	(2) The professional conduct committee shall act in panels of 3 members of the committee to be selected in the manner determined by the board of directors.	"Professional Conduct Committee", a name which is more in keeping with this committee's functions and objectives.
(3) A panel of 3 members constitutes a quorum of the committee, notwithstanding that notice of the meeting may not have been given to other members of the committee.	(3) Any panel of three members of the committee has the power and authority of the professional conduct committee to act upon any inquiry or matter referred to it.	
(4) The discipline committee may inquire into the conduct of a member, and for that purpose each member of the committee has all the powers, protection and privileges of a commissioner under sections 12, 15 and 16 of the Inquiry Act.	(4) The professional conduct committee may inquire into the conduct of a member and, for that purpose, each member of the committee has the same protection and privileges for an act done or omitted to be done in the execution of her duty as are by law given to judges of the Supreme Court.	It is proposed that, instead of incorporating by reference Sections 12, 15 and 16 of the Inquiry Act, those powers and protections be set out in the proposed Nurses (Registered) Act. The latter part of subsection (4) is the equivalent of Section 12 of the Inquiry Act. Subsections (5) and (6) are abbreviated and modified versions of Sections 15 and 16 of the Inquiry Act. An additional power has been added to compel the attendance of a witness before a person authorized to conduct a preliminary investigation.
(5) The discipline committee may make or direct another person to make preliminary investigation into the conduct of a member.	(5) Any member of the professional conduct committee may issue a subpoena to compel the attendance of a person as a witness before an inquiry, or before a person authorized by the chairman of the professional conduct committee to make a preliminary investigation, and may in the subpoena require the person to produce records or things in her possession or control relating to the subject matter of the inquiry or investigation.	
	(6) The failure or refusal of a person to comply with a subpoena, including a failure or refusal to attend as a witness, to give evidence, to take an oath or affirmation or to produce records or things in her possession or control, makes the person, on application by the association to the Supreme Court, liable to be committed for contempt as if in breach of an order of the Supreme Court.	Because the chairman of the professional conduct committee is involved in the pre-inquiry stage (cross-reference: section 36 - authorization of preliminary investigations; section 37(1) - directing the issuance of a citation) it was considered inappropriate for the chairman to sit as a panel member of any hearing by the committee.

Nurses (Registered) Act (as it Presently Exists)	Nurses (Registered) Act (with Proposed Amendments)	Explanatory Comments on Proposed Amendments
	(7) The chairman of the professional conduct committee shall not sit as a member of a panel of the committee on a hearing by the committee under section 37.	
	Preliminary Investigation 36.(1) The chairman of the professional conduct committee may authorize a person to make a preliminary investigation into the conduct of a member. (2) A person authorized to make a preliminary investigation under subsection (1) may request any person to answer any question and to produce to her any document or record relevant to the preliminary investigation. (3) A person to whom a request is made under subsection (2) shall be entitled to comply with the request.	Section 36 - Preliminary Investigation Subsection (1) corresponds with section 22(5) of the present Act. This subsection has been amended so that the professional conduct committee will not itself conduct investigations into the conduct of members. Instead, the chairman of the committee will only authorize another person, e.g., an investigations officer of the association, to conduct the preliminary investigation. Subsections (2) and (3) are intended to clarify the authority of an authorized investigator to obtain information and documents relevant to a preliminary investigation.
Inquiry 23.(1) An inquiry under section 22(4) shall be by a hearing commenced by a citation issued at the direction of the chairman of the discipline committee and served to the person whose conduct is under inquiry. (2) A citation shall be served either personally or by registered mail. (3) Where a citation is served personally, it must be served at least 10 days before the hearing. (4) Where a citation is served by registered mail, it must be	Inquiry 37.(1) An inquiry under section 35(4) shall be a hearing commenced by a citation issued at the direction of the chairman of the professional conduct committee and served on the member whose conduct is under inquiry. (2) A citation shall be served either personally or by registered mail. (3) Where a citation is served personally, it must be served at least 10 days before the hearing. (4) Where a citation is served by registered mail, it must be	Section 37 - Inquiry This section corresponds with section 23 of the present Act. The amendments made are of a minor and technical nature.

Nurses (Registered) Act (as it Presently Exists)	Nurses (Registered) Act (with Proposed Amendments)	Explanatory Comments on Proposed Amendments
(a) addressed to the person whose conduct is under inquiry at her last known address as shown by the records of the association; and	(a) addressed to the member whose conduct is under inquiry at her last known address as shown by the records of the association; and	
(b) mailed at least 14 days before the hearing,	(b) mailed at least 14 days before the hearing.	
and, if those conditions are met, it shall be deemed to have been served.	and, if those conditions are met, it shall be deemed to be been served.	
(5) A citation shall state the nature of the conduct to be inquired into, and shall specify the time and place of the hearing.	(5) A citation shall state the nature of the conduct to be inquired into, and shall specify the time and place of the hearing.	
Suspension pending hearing	Suspension pending hearing	Section 38 - Suspension Pending Hearing
24.(1) Where the chairman of the discipline committee has directed that a citation be issued under section 23, the discipline committee may, without a hearing, temporarily suspend the member whose conduct is under inquiry until a final decision is made under section 26 or until the discipline committee decides otherwise, and written notice of the temporary suspension shall immediately be served on the member in the same manner as a citation is served.	38.(1) Where the chairman of the professional conduct committee has directed that a citation be issued under section 37, the professional conduct committee may, without a hearing, temporarily suspend the membership of the member whose conduct is under inquiry until a final decision is made under section 40 or until the professional conduct committee decides otherwise, and written notice of the temporary suspension shall immediately be served on the member in the same manner as a citation is served.	This section corresponds with section 24 of the present Act. The amendments are of a minor and technical nature.
(2) Where the discipline committee has suspended a member under subsection (1), the member may apply to the Supreme Court for a stay of the suspension until a final decision of the discipline committee is made under section 26, and the court may dispose of the application as it considers proper	(2) Where the professional conduct committee has suspended a member under subsection (1), the member may apply to the Supreme Court for a stay of the suspension until a final decision of the professional conduct committee is made under section 40, and the court	

Nurses (Registered) Act (as it Presently Exists)	Nurses (Registered) Act (with Proposed Amendments)	Explanatory Comments on Proposed Amendments
and in doing so may impose terms and conditions it considers appropriate.	may dispose of the application as it considers proper and in doing so it may impose terms and conditions it considers appropriate.	
Procedure	Procedure	Section 39 - Procedure
25.(1) On a hearing or an appeal under section 28, the discipline committee or the board of directors and the person whose conduct is the subject of inquiry have the right to be represented by counsel and to submit evidence.	39.(1) On a hearing under section 37 or on an appeal under section 42, the association and the member or person appealing have the right to be represented by counsel and to submit evidence.	This section corresponds with section 25 of the present Act. The amendments are of a minor and technical nature.
(2) On a hearing by the discipline committee, the testimony of witnesses shall be taken under oath, which the presiding chairman of the panel of the discipline committee may administer, and there shall be full right of cross examination.	(2) On a hearing by the professional conduct committee, the testimony of witnesses shall be taken under oath, which the presiding chairman of the panel of the professional conduct committee may administer, and there shall be full right of cross examination.	
(3) If the person whose conduct is the subject of inquiry does not attend the hearing, the discipline committee may, on proof, by affidavit or otherwise, of service of the citation under section 23, proceed with the inquiry in the absence of the person whose conduct is the subject of inquiry and, without further notice to that person, take any action it is authorized to take under this Act.	(3) If the member whose conduct is the subject of inquiry does not attend the hearing the professional conduct committee may, on proof, by affidavit or otherwise, of service of the citation under section 37, proceed with the inquiry in the absence of the member and, without further notice to the member, take any action it is authorized to take under this Act.	
(4) The discipline committee may cause the evidence before it or any part of the evidence to be taken down in shorthand or other similar method and transcribed, and the presiding chairman of the panel of the discipline committee may administer an oath to the stenographer or person employed.	(4) The professional conduct committee may cause the whole or any part of the evidence before it to be recorded and transcribed and the presiding chairman of the panel of the committee may administer an oath to the person employed to record and transcribe the evidence.	

Nurses (Registered) Act (as it Presently Exists)	Nurses (Registered) Act (with Proposed Amendments)	Explanatory Comments on Proposed Amendments
Finding by discipline committee	Finding by professional conduct committee	Section 40 - Finding by a Professional Conduct Committee
26. The discipline committee, after a hearing under section 23, may	40. The professional conduct committee, after a hearing under section 37 may	This section corresponds with section 26 of the present Act. The amendments are of a minor and technical nature.
(a) inform the member that she is exonerated of wrongdoing;	(a) inform the member that she is exonerated of wrongdoing;	
(b) dismiss the citation;	(b) dismiss the citation;	
(c) determine that the member is or has been	(c) determine that the member has	
(i) guilty of incompetence;	(i) been or is incompetent;	
(ii) guilty of conduct contrary to the ethical standards of the profession of nursing;	(ii) engaged in conduct contrary to ethical standards of the profession of nursing;	
(iii) guilty of a breach of this Act or the constitution and bylaws of the association; or	(iii) committed a breach of this Act, the rules or the constitution and bylaws; or	
(iv) guilty of fraud or misrepresentation in obtaining membership in the association;	(iv) committed fraud or misrepresentation in obtaining or renewing membership in the association;	
(d) determine that the member is or has been	(d) determine that the member's ability to engage in the practice of nursing is or has been impaired by reason of	The amendment in (d) deletes the words "incapable of nursing" and introduces the concept of impairment of ability to practice. There are varying degrees of impairment ranging from total incapacity, which would justify total withdrawal of the right to practice, to less severe forms of impairment, which might result in only a restriction on practice.
(i) incapable of nursing by reason of a physical or mental condition of a nature or extent that it is desirable in the interests of the public or the member that she no longer be permitted to practise; or	(i) a physical or mental condition, or	
(ii) incapable of nursing by reason of a habit or	(ii) a habit or condition, resulting from addiction to or abuse or misuse of alcohol or drugs	
	of a nature and extent that it	

Nurses (Registered) Act (as it Presently Exists)	Nurses (Registered) Act (with Proposed Amendments)	Explanatory Comments on Proposed Amendments
condition, resulting from addiction to or abuse or misuse of alcohol or drugs, of a nature and extent that it is desirable in the interests of the public or the member that she no longer be permitted to practise; or	is desirable in the interests of the public or the member that she no longer be permitted to practice or that her practice be restricted; or	
(e) make another disposition of the citation it considers proper.	(e) make any other disposition of the citation it considers proper.	
Disciplinary action	Corrective Actions	Section 41 - Corrective Actions
27.(1) The discipline committee, after making a decision under section 26(c), (d) or (e), may	41.(1) The professional conduct committee, after making a decision under section 40(c), (d) or (e) may	This section corresponds with section 27 of the present Act. The amendments are of a minor and technical nature.
(a) reprimand or censure the member;	(a) reprimand or censure the member;	
(b) suspend the member for the period of time, either definite or indefinite, and on the terms and conditions the discipline committee in its discretion thinks proper;	(b) impose conditions on the continuance of the membership of the member; or	
(c) impose conditions on the continuance of the membership of the member; or	(c) suspend the membership of the member for the period of time, either definite or indefinite, and on the terms and conditions the professional conduct committee in its discretion thinks proper;	
(d) terminate the member's membership by striking her name from the register,	(d) terminate the member's membership,	
or any combination of them.	or any combination of them.	
(2) The discipline committee, where it considers it proper, may suspend its decision on the terms and for the period it considers proper.	(2) The professional conduct committee, where it considers it proper, may suspend its decision on the terms and for the period it considers proper.	

Nurses (Registered) Act (as it Presently Exists)	Nurses (Registered) Act (with Proposed Amendments)	Explanatory Comments on Proposed Amendments
(3) A decision of the discipline committee under sections 26 and 27 shall be in writing and shall contain or be accompanied by the reasons for the decision, in writing.	(3) A decision of the professional conduct committee under sections 40 and 41 shall be in writing and shall contain or be accompanied by the reasons for the decision, in writing.	
(4) A copy of the decision and the reasons, together with a notice to the person whose conduct is under inquiry of his right to appeal under section 28, shall be served by the association on the member who is the subject of the inquiry in the manner set out in section 23(2) within 30 days after the date of the decision.	(4) A copy of the decision and the reasons, together with a notice of the right to appeal the decision under section 42, shall be served by the association on the member in the manner set out in section 37(2) within 30 days after the date of the decision.	
	(5) The professional conduct committee may, upon cause being shown, vary or rescind any terms or conditions imposed under paragraphs (b) or (c) of subsection (1) or under subsection (2).	
Appeal	Appeal	Section 42 - Appeal
28.(1) A person who has been refused examination or concerning whom action has been ordered under section 27(1) may appeal to the board of directors.	42.(1) A person (a) who has been refused examination by the board of examiners; (b) whose application for renewal of membership has been refused, or (c) concerning whom action has been ordered under section 41 may appeal to the board of directors.	This section corresponds with section 28 of the present Act. The only significant amendment is that paragraph (b) has been added to subsection (1) to provide a right of appeal to a member whose application for renewal of membership has been refused.
(2) An appeal under this section must be commenced by serving the chairman of the board of directors or, if she cannot be served, by serving another director with a notice of appeal within 15 days after the day on which the person appealing is served with the decision of the board of examiners or discipline committee.	(2) An appeal under this section must be commenced by serving the chairman of the board of directors or, if she cannot be served, by serving another director,	
(3) On the request of a person who wishes to appeal and on payment at the rate of charges in force in the office of the official stenographer of the		

Nurses (Registered) Act (as it Presently Exists)	Nurses (Registered) Act (with Proposed Amendments)	Explanatory Comments on Proposed Amendments
Supreme Court, the board of examiners or discipline committee shall provide that person and the board of directors with a certified copy of the transcript, if any, of the proceedings before the discipline committee, and all records on which the discipline committee made its decision.	with a notice of appeal within 15 days after the day on which the appellant is served with the decision appealed from. (3) On the request of an appellant and on payment by her of the cost thereof, the professional conduct committee shall provide the appellant and the board of directors with a certified copy of the transcript, if any, of the evidence adduced before the professional conduct committee, and all records on which the professional conduct committee made its decision.	
(4) On appeal, the board of directors shall consider the transcript, if any, and the records referred to in subsection (3), but may receive and consider other evidence.	(4) On an appeal, the board of directors shall consider the transcript, if any, and the records referred to in subsection (3), but may receive and consider other evidence.	
(5) On the hearing of an appeal under this section, the board of directors may	(5) On the hearing of an appeal under this section, the board of directors may	
(a) make an order confirming, reversing or varying the decision of the board of examiners or discipline committee;	(a) make an order confirming, reversing or varying the decision appealed from;	
(b) refer the matter back to the board of examiners or discipline committee with or without directions; or	(b) refer the matter back to the board of examiners, the professional conduct committee, or other committee that made the decision appealed from, with or without directions; or	
(c) make the order it considers proper in the circumstances.	(c) make the order it considers proper in the circumstances;	
(6) No member of the association who sat on the board of examiners or discipline committee when the decision appealed from was made shall take part in the hearing of the appeal before the board of directors.	(6) No member of the board of examiners, the professional conduct committee or other committee who participated in making the decision appealed from, shall take part in the hearing of the appeal before the board of directors.	

Nurses (Registered) Act (as it Presently Exists)	Nurses (Registered) Act (with Proposed Amendments)	Explanatory Comments on Proposed Amendments
Further appeal to court	Further appeal to court	Section 43 - Further Appeal to Court
29.(1) A person who feels herself aggrieved or adversely affected by an order or decision of the board of directors under section 28 may appeal to the Supreme Court within 30 days after the date of the refusal or order.	43.(1) A person who is aggrieved or adversely affected by an order or decision of the board of directors under section 42 may appeal to the Supreme Court within 30 days after the date of the order or decision.	This section corresponds with section 29 of the present Act. The amendments are of a minor and technical nature.
(2) The appellant shall file a notice of appeal with the registrar of the Supreme Court and shall serve a copy of the notice of appeal on the chairman of the board of directors or any other director, within the time limited under subsection (1).	(2) The appellant shall file a notice of appeal with the registrar of the Supreme Court and shall serve a copy of the notice of appeal on the chairman of the board of directors or, if she cannot be served, by serving another director, within the time limited under subsection (1).	
(3) The board of directors, on the request of the appellant, shall furnish to her certified copies of all records on which the board of examiners, the discipline committee or the board of directors acted, on payment for copies at the same rate as would be charged for the same service by an official stenographer of the Supreme Court.	(3) On the request of the appellant and on payment by the appellant of the cost thereof, the board of directors shall furnish to her certified copies of the transcript of evidence and all records on which the board of examiners, the professional conduct committee, other committee or the board of directors acted.	
(4) The appeal shall be	(4) The appeal shall be	
(a) a new hearing where there is no transcript; or	(a) a new hearing where there is no transcript; or	
(b) a review of the transcript and proceedings where there is a transcript; but the court may, where it considers it necessary in the interests of justice, conduct a new hearing or allow the introduction of new evidence.	(b) a review of the transcript and proceedings where there is a transcript; but the court may, where it considers it necessary in the interests of justice, conduct a new hearing, or allow the introduction of new evidence.	
5. The board of directors is entitled to be a party on the hearing of the appeal and		

Nurses (Registered) Act (as it Presently Exists)	Nurses (Registered) Act (with Proposed Amendments)	Explanatory Comments on Proposed Amendments
may take part in the proceedings.	(5) The association is entitled to be a party on the hearing of the appeal and may take part in the proceedings.	
(6) The Supreme Court Rules apply with respect to the procedure on an appeal under this section and the court may give the directions it considers necessary to ensure the proper hearing of the appeal.	(6) The Supreme Court Rules apply with respect to the procedure on an appeal under this section and the court may give the directions it considers necessary to ensure the proper hearing of the appeal.	
(6) On the hearing of an appeal under this section, the Supreme Court may (a) make an order confirming, reversing or varying the decision of the board of directors; (b) refer the matter back to the board of directors with or without directions; or (c) make the order it considers proper in the circumstances.	(7) On the hearing of an appeal under this section, the Supreme Court may (a) make an order confirming, reversing or varying the decision of the board of directors; (b) refer the matter back to the board of directors with or without directions; or (c) make the order it considers proper in the circumstances.	
Costs	Costs	Section 44 - Costs
30. The discipline committee may order a member concerning whom an action has been ordered under section 27 to pay all or part of the reasonable expenses incurred by the association in the investigation or hearing preceding that decision.	44. The professional conduct committee may order a member concerning whom an action has been ordered under section 41 to pay all or part of the reasonable expenses incurred by the association in the investigation or hearing preceding that order.	This section corresponds with section 30 of the present Act. The amendments are of a minor and technical nature.

Nurses (Registered) Act (as it Presently Exists)	Nurses (Registered) Act (with Proposed Amendments)	Explanatory Comments on Proposed Amendments
Effect of suspension	Effect of suspension	Section 45 - Effect of Suspension
31. Where a person is suspended, the board of directors shall make a notation of the terms and duration of the suspension in the register, and throughout the period of the suspension the person shall be deemed not to be a member except for the purposes of an investigation or inquiry under section 22 and resulting disciplinary proceedings.	45. Where the membership of a member is suspended, the board of directors shall cause a notation of the terms and duration of the suspension to be made in the register, the licensed graduate nurse roster or the student membership roll and throughout the period of the suspension the member (a) shall be deemed not to be a member except for the purpose of a preliminary investigation or inquiry under section 36 and any resulting proceedings; and (b) shall not be authorized to engage in the practice of nursing except to the extent permitted by the terms and conditions of the suspension.	This section corresponds with section 31 of the present Act. This section has been amended to make reference to the licensed graduate nurse roster and the student membership roll. It has also been amended to provide that a suspended member will not be authorized to engage in the practice of nursing except to the extent permitted by the terms and conditions of her suspension.
Effect of termination by decision	Effect of termination by decision	Section 46 - Effect of Termination by Decision
32.(1) Where a person's membership is terminated by a decision under section 27, the name of that person shall not again be entered on the register except by the direction of the board of directors, who may direct that the entry will not be made until a fee set by the board of directors is paid. (2) Where a person's membership is terminated by a decision under section 27, she shall immediately deliver her certificate of registration to the registered offices of the association.	46.(1) Where a person's membership is terminated by a decision under section 41, that person shall not be reinstated to membership except by the decision of the board of directors made pursuant to section 20. (2) Where a person's membership is terminated by a decision under section 41, she shall immediately deliver her certificate of membership to the office of the association.	This section corresponds with section 32 of the present Act. The only significant amendment is to subsection (1). That subsection has been amended so as to direct applications for reinstatement from terminated members to the board of directors under section 20.

Nurses (Registered) Act (as it Presently Exists)	Nurses (Registered) Act (with Proposed Amendments)	Explanatory Comments on Proposed Amendments
Effect of termination by nonpayment	Effect of nonpayment or resignation	Section 47 - Effect of Non-Payment or Resignation
33.(1) Where a person's membership is terminated by failure to pay the annual fee before March 1, and	47.(1) Where a person's membership ceases by reason of failure to pay the annual membership fees or by resignation, and	This section corresponds with section 33 of the present Act. The amendments are of a minor and technical nature.
(a) the discipline committee is at that time conducting a preliminary investigation or an inquiry into the conduct of that person; or	(a) the chairman of the professional conduct committee has authorized a preliminary investigation or the professional conduct committee has commenced an inquiry, into the conduct of that person; or	
(b) the board of directors decide at a later date that grounds exist for a preliminary investigation or an inquiry by the discipline committee into the conduct of that person,	(b) the board of directors decide at a later date that grounds exist for a preliminary investigation, or an inquiry by the professional conduct committee, into the conduct of that person.	
the board of directors may require that the preliminary investigation or inquiry into the conduct of that person be concluded or that a preliminary investigation or inquiry into the conduct of that person be conducted by the discipline committee, before permitting that person's name to be entered again on the register.	the board of directors may require that the preliminary investigation or inquiry into the conduct of that person be concluded or that a preliminary investigation or inquiry into the conduct of that person be conducted before permitting the reinstatement of that person's membership.	
(2) For the purposes of this section and a preliminary investigation or an inquiry under it, a former member shall be deemed a member; but she shall have none of the rights or privileges of a member and shall not be deemed a registered nurse.	(2) For the purposes of this section and a preliminary investigation or an inquiry under it, a former member shall be deemed to remain a member; but she shall have none of the rights or privileges attached to her former membership.	

Nurses (Registered) Act (as it Presently Exists)	Nurses (Registered) Act (with Proposed Amendments)	Explanatory Comments on Proposed Amendments
Continuation of member of discipline committee	Continuation of member of professional conduct committee	Section 48 - Continuation of Member of Professional Conduct Committee
34. Where a hearing is begun under section 23, and the term of office on the discipline committee of a member sitting for the hearing expires or is terminated before the proceeding is disposed of and after evidence has been heard, the member remains a member of the discipline committee for the purpose of completing the disposition of the proceeding; but she is not, for any other purpose, a member of the discipline committee beyond the date of expiry or termination.	48. Where a hearing is commenced under section 37, and the term of office on the professional conduct committee of a member sitting for the hearing expires or is terminated before the proceeding is disposed of and after evidence has been heard, the member remains a member of the professional conduct committee for the purpose of completing the disposition of the proceeding; but she is not, for any other purpose, a member of the professional conduct committee beyond the date of expiry or termination.	This section corresponds with section 34 of the present Act. The amendments are of a minor and technical nature.
Suspension, termination without hearing	Suspension, termination without hearing	Section 49 - Suspension, Termination Without Hearing
35.(1) On proof that a member has been convicted of an indictable offence, the board of directors may, without reference to the discipline committee, summarily order the suspension of the member or the termination of her membership.	49.(1) On proof that a member has been convicted of an indictable offence, the board of directors may, without reference to the professional conduct committee, summarily order the suspension or the termination of her membership.	This section corresponds with section 35 of the present Act.
(2) On proof that a member is suffering from a physical or mental condition, and on being satisfied that a citation served under section 23 may worsen the condition of the member or that she would not understand the citation, the board of directors may, without reference to the discipline committee, summarily order the suspension of the member or the termination of her membership.	(2) On proof that a member is suffering from a physical or mental condition, and on being satisfied that serving of a citation or holding a hearing under section 37 may worsen the condition of the member or that she would not understand the citation or the proceedings at the hearing, the board of directors may, without reference to the professional conduct committee, summarily order the suspension or termination of the membership of the member.	The only significant amendment is to subsection (2). The amendment will allow the board of directors to act under this subsection where it is satisfied that the holding of a hearing under section 37 might worsen the condition of the member or that she would not understand the proceedings at the hearing.

Nurses (Registered) Act (as it Presently Exists)	Nurses (Registered) Act (with Proposed Amendments)	Explanatory Comments on Proposed Amendments
(3) Where the board of directors has suspended a member or terminated her membership under subsection (2), the member may apply to the Supreme Court for a stay of the order pending an inquiry under section 23, and the court may dispose of the application as it considers proper and in doing so it may impose the terms and conditions it considers appropriate.	(3) Where the board of directors has suspended or terminated the membership of a member under subsection (2), the member may apply to the Supreme Court for a stay of the order pending a hearing under section 37, and the court may dispose of the application as it considers proper and in doing so it may impose terms and conditions it considers appropriate.	
Protection against liability	Protection against liability	Section 50 - Protection Against Liability
36. No liability is incurred by the association, the board of directors or the discipline committee or by a committee or member of those bodies or by an officer, employee, agent or appointee of the association, for an act done in good faith in the performance or intended performance of a duty or in the exercise or intended exercise of a power under this Act, a regulation, the constitution or a bylaw or for neglect or default in the performance or exercise in good faith of that duty or power.	50. No liability is incurred by the association, the board of directors, any committee or board established under this Act, the rules or the constitution and by-laws, or by any member of those bodies, or by any employee, agent or appointee of the association, for any act done or omitted in the performance of a duty or in the exercise or intended exercise of power under this Act, the rules or the constitution and bylaws, whether the act was done or omitted negligently, so long as the act was done or omitted in good faith.	This section corresponds to section 36 of the present Act. The amended section now deals more explicitly with omissions to act. Also, liability for negligence is expressly excluded. Finally, reference in this section to the professional conduct committee has been removed; the professional conduct committee will be protected from liability by the new section 35(4) set out above.
Exemptions	Exemption	Section 51 - Exemption
40.(1) This Act shall not be construed to affect or apply to the gratuitous nursing of the sick by friends or members of the family of the sick person, or to a person nursing the sick for hire who does not assume or pretend to be a registered nurse. (2) Part 10 of the Employment Standards Act does not apply to the	51. Part 10 of the Employment Standards Act does not apply to the association or to a placement service for its members operated by it or to a member of the association utilizing the service.	This section corresponds to section 40 of the present Act. The only significant amendment is the deletion of subsection (1) from section 40 of the present Act. The exemption in that subsection provided for the gratuitous nursing of the sick by friends or family members is now dealt with in section 29(a). The remainder

Nurses (Registered) Act (as it Presently Exists)	Nurses (Registered) Act (with Proposed Amendments)	Explanatory Comments on Proposed Amendments
association or to a placement service for its members operated by it or to a member of the association utilizing the service.		of the exemption in subsection (1), dealing with persons nursing the sick for hire without assuming or pretending to be a registered nurse, has been deleted since it is inconsistent with mandatory registration.

Note: From Registered Nurses' Association of British Columbia (no date). Used with permission.

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